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Attorneys for Motors Liquidation
Company GUC Trust

**UNITED STATES BANKRUPTCY COURT
SOUTHERN DISTRICT OF NEW YORK**

-----X	
	:
In re	:
	:
MOTORS LIQUIDATION COMPANY, <i>et al.</i>,	:
f/k/a General Motors Corp., <i>et al.</i>	:
	:
Debtors.	:
	:
	:
-----X	

Chapter 11 Case No.
09-50026 (REG)
(Jointly Administered)

**NOTICE OF OBJECTION TO
PROOF OF CLAIM 28560 FILED BY ALICIA E. CALHOUN**
(Splinter Union Employee Claim)

PLEASE TAKE NOTICE that on September 14, 2012, the Motors Liquidation Company GUC Trust (the “**GUC Trust**”), formed by the above-captioned debtors (collectively, the “**Debtors**”) in connection with the Debtors’ Second Amended Joint Chapter 11 Plan, dated March 18, 2011, filed an objection to disallow and expunge proof of claim 28560 filed by Alicia E. Calhoun (the “**Objection to Claim**”), and that a hearing (the “**Hearing**”) to consider the Objection to Claim will be held before the Honorable Robert E. Gerber, United States Bankruptcy Judge, in Room 523 of the United States Bankruptcy Court for the Southern District of New York, One Bowling Green, New York, New York 10004, on **October 15, 2012 at 9:45 a.m. (Eastern Time)**, or as soon thereafter as counsel may be heard.

PLEASE TAKE FURTHER NOTICE that any response or objection to this Objection to Claim must be in writing, shall conform to the Federal Rules of Bankruptcy Procedure and the Local Rules of the Bankruptcy Court, and shall be filed with the Bankruptcy Court (a) electronically in accordance with General Order M-399 (which can be found at www.nysb.uscourts.gov) by registered users of the Bankruptcy Court's filing system, and (b) by all other parties in interest, on a CD-ROM or 3.5 inch disk, in text-searchable portable document format (PDF) (with a hard copy delivered directly to Chambers), in accordance with the customary practices of the Bankruptcy Court and General Order M-399, to the extent applicable, and served in accordance with General Order M-399 and on (i) Weil, Gotshal & Manges LLP, attorneys for the GUC Trust, 767 Fifth Avenue, New York, New York 10153 (Attn: Harvey R. Miller, Esq., Stephen Karotkin, Esq., and Joseph H. Smolinsky, Esq.); (ii) the Debtors, c/o Motors Liquidation Company, 401 South Old Woodward Avenue, Suite 370, Birmingham, Michigan 48009 (Attn: Thomas Morrow); (iii) General Motors LLC, 400 Renaissance Center, Detroit, Michigan 48265 (Attn: Lawrence S. Buonomo, Esq.); (iv) Cadwalader, Wickersham & Taft LLP, attorneys for the United States Department of the Treasury, One World Financial Center, New York, New York 10281 (Attn: John J. Rapisardi, Esq.); (v) the United States Department of the Treasury, 1500 Pennsylvania Avenue NW, Room 2312, Washington, D.C. 20220 (Attn: Joseph Samarias, Esq.); (vi) Vedder Price, P.C., attorneys for Export Development Canada, 1633 Broadway, 47th Floor, New York, New York 10019 (Attn: Michael J. Edelman, Esq. and Michael L. Schein, Esq.); (vii) Kramer Levin Naftalis & Frankel LLP, attorneys for the statutory committee of unsecured creditors, 1177 Avenue of the Americas, New York, New York 10036 (Attn: Thomas Moers Mayer, Esq., Robert Schmidt, Esq., Lauren Macksoud, Esq., and Jennifer Sharret, Esq.); (viii) the Office of the United States Trustee for the Southern District of

New York, 33 Whitehall Street, 21st Floor, New York, New York 10004 (Attn: Tracy Hope Davis, Esq.); (ix) the U.S. Attorney's Office, S.D.N.Y., 86 Chambers Street, Third Floor, New York, New York 10007 (Attn: David S. Jones, Esq. and Natalie Kuehler, Esq.); (x) Caplin & Drysdale, Chartered, attorneys for the official committee of unsecured creditors holding asbestos-related claims, 375 Park Avenue, 35th Floor, New York, New York 10152-3500 (Attn: Elihu Inselbuch, Esq. and Rita C. Tobin, Esq.) and One Thomas Circle, N.W., Suite 1100, Washington, DC 20005 (Attn: Trevor W. Swett III, Esq. and Kevin C. MacLay, Esq.); (xi) Stutzman, Bromberg, Esserman & Plifka, A Professional Corporation, attorneys for Dean M. Trafelet in his capacity as the legal representative for future asbestos personal injury claimants, 2323 Bryan Street, Suite 2200, Dallas, Texas 75201 (Attn: Sander L. Esserman, Esq. and Robert T. Brousseau, Esq.); (xii) Gibson, Dunn & Crutcher LLP, attorneys for Wilmington Trust Company as GUC Trust Administrator and for Wilmington Trust Company as Avoidance Action Trust Administrator, 200 Park Avenue, 47th Floor, New York, New York 10166 (Attn: Keith Martorana, Esq.); (xiii) FTI Consulting, as the GUC Trust Monitor and as the Avoidance Action Trust Monitor, One Atlantic Center, 1201 West Peachtree Street, Suite 500, Atlanta, Georgia 30309 (Attn: Anna Phillips); (xiv) Crowell & Moring LLP, attorneys for the Revitalizing Auto Communities Environmental Response Trust, 590 Madison Avenue, 19th Floor, New York, New York 10022-2524 (Attn: Michael V. Blumenthal, Esq.); and (xv) Kirk P. Watson, Esq., as the Asbestos Trust Administrator, 2301 Woodlawn Boulevard, Austin, Texas 78703, so as to be received no later than **October 8, 2012, at 4:00 p.m. (Eastern Time)** (the "**Response Deadline**").

PLEASE TAKE FURTHER NOTICE that if no response is timely filed and served with respect to the Objection to Claim, the GUC Trust may, on or after the Response

Deadline, submit to the Bankruptcy Court an order substantially in the form of the proposed order annexed to the Objection to Claim, which order may be entered with no further notice or opportunity to be heard offered to any party.

Dated: New York, New York
September 14, 2012

/s/ Joseph H. Smolinsky

Harvey R. Miller

Stephen Karotkin

Joseph H. Smolinsky

WEIL, GOTSHAL & MANGES LLP

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New York, New York 10153

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**UNITED STATES BANKRUPTCY COURT
SOUTHERN DISTRICT OF NEW YORK**

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In re	: Chapter 11 Case No.
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MOTORS LIQUIDATION COMPANY, et al.,	: 09-50026 (REG)
f/k/a General Motors Corp., et al.	:
	:
Debtors.	: (Jointly Administered)
	:
-----X	

**OBJECTION TO
PROOF OF CLAIM 28560 FILED BY ALICIA E. CALHOUN
(Splinter Union Employee Claim)**

TO THE HONORABLE ROBERT E. GERBER,
UNITED STATES BANKRUPTCY JUDGE:

The Motors Liquidation Company GUC Trust (the “**GUC Trust**”), formed by the above-captioned debtors (collectively, the “**Debtors**”) in connection with the Debtors’ Second Amended Joint Chapter 11 Plan, dated March 18, 2011 (as may be amended, supplemented, or modified from time to time, the “**Plan**”), respectfully represents:

Relief Requested

1. The GUC Trust files this objection (the “**Objection to Claim**”) pursuant to section 502(b) of title 11, United States Code (the “**Bankruptcy Code**”) and Rule 3007 of the Federal Rules of Bankruptcy Procedure (the “**Bankruptcy Rules**”), seeking entry of an order

disallowing and expunging Proof of Claim No. 28560 filed by Alicia E. Calhoun,¹ a former employee of the Debtors represented by the IUE-CWA union (the “**Splinter Union Employee**”). Neither the Debtors nor the GUC Trust currently employs any individuals who are represented by any union and who work within the United States.²

2. Representatives of the GUC Trust have examined the proof of claim annexed as **Exhibit “A”** hereto³ (the “**Splinter Union Employee Claim**”) and determined that it relates to liabilities that, even if true as alleged, have been settled pursuant to the terms of that certain *Settlement Agreement Between and Among GMCo/MLC-IUE-CWA and USW Regarding Retiree Health Care, Life Insurance, Pension Top-Up, and Modification and GMCo Assumption of MLC-IUE-CWA CBA* dated as of September 3, 2009, by and among General Motors Corporation, the IUE-CWA, the Industrial Division of the Communications Workers of America, AFL-CIO, CLC, and the United Steel, Paper and Forestry, Rubber, Manufacturing, Energy, Allied Industrial and Service Workers International Union, AFL-CIO, CLC (the “**Original Settlement Agreement**”), and is therefore not a liability of the Debtors or the GUC Trust.⁴

3. The Splinter Union Employee Claim relates to the nonpayment of wages as a result of an alleged wrongful termination. The Settlement Agreement resolved all claims of

¹ Creditors can obtain copies of the cover page of any proof of claim filed in these chapter 11 cases at www.motorsliquidation.com. A link to the claims register is located under the “Claims Information” tab. Creditors without access to the internet may request a copy of the cover page of any proof of claim by mail to The Garden City Group, Inc., Motors Liquidation Company Claims Agent, P.O. Box 9386, Dublin, Ohio 43017-4286 or by calling The Garden City Group, Inc. at 1-703-286-6401.

² The GUC Trust reserves all of its rights to object on any other basis to the Splinter Union Employee Claim to the extent the Court does not grant the relief requested herein.

³ Proof of Claim No. 28560 filed by Alicia E. Calhoun contains two copies of the same proof of claim. For the avoidance of doubt, the GUC Trust has included the full copy of Proof of Claim No. 28560 as it appears on the claims register.

⁴ Certain Splinter Unions subsequently joined the Original Settlement Agreement pursuant to Supplemental Agreements (each as listed and defined below) (and together with the Original Settlement Agreement, the “**Settlement Agreement**”).

employees of all unions representing former employees of the Debtors other than the United Auto Workers, collectively the “**Splinter Union Employees**”). Pursuant to the Settlement Agreement, New GM has agreed to provide certain benefits to the Splinter Union Employees. The Settlement Agreement encompasses claims related to the employment and/or retirement benefits of the Splinter Union Employees, and in particular claims related to nonpayment of wages, discrimination, harassment, wrongful termination or other detrimental job actions, or a combination thereof, as well as claims related to benefits provided under certain welfare benefit plans (collectively, the “**Benefit Plans**”) and include (without limitation) the reduction, elimination or waiver of any pension, medical, dental, vision, long term disability, short term disability, life, accidental death and dismemberment, personal accident, and other insurance benefits, severance, and other welfare and fringe benefits of former and retired employees (together, the “**Settled Claims**”).

4. The Splinter Union Employee Claim is a Settled Claim under the Settlement Agreement and, therefore, is not a liability of Motors Liquidation Company (“**MLC**”), the Debtors, or the GUC Trust, and should therefore be disallowed and expunged from the claims register.

Jurisdiction

5. This Court has jurisdiction to consider this matter pursuant to 28 U.S.C. §§ 157 and 1334. This is a core proceeding pursuant to 28 U.S.C. § 157(b).

Background

6. On June 1, 2009 (the “**Commencement Date**”), Motors Liquidation Company (f/k/a General Motors Corporation), MLCS, LLC (f/k/a Saturn, LLC), MLCS Distribution Corporation (f/k/a Saturn Distribution Corporation), and MLC of Harlem, Inc. (f/k/a Chevrolet-Saturn of Harlem, Inc.) (collectively, the “**Initial Debtors**”) commenced with this

Court voluntary cases under chapter 11 of the Bankruptcy Code, and on October 9, 2009, Remediation and Liability Management Company, Inc. and Environmental Corporate Remediation Company, (the “**REALM/ENCORE Debtors**”) commenced with this Court voluntary cases under chapter 11 of the Bankruptcy Code, which cases are jointly administered under Case Number 09-50026 (REG). On September 15, 2009, the Initial Debtors filed their schedules of assets and liabilities and statements of financial affairs, which were amended on October 4, 2009. On October 15, 2009, the REALM/ENCORE Debtors filed their schedules of assets and liabilities and statements of financial affairs.

7. On September 16, 2009, this Court entered an order (ECF No. 4079) establishing November 30, 2009 as the deadline for each person or entity to file a proof of claim in the Initial Debtors’ cases, including governmental units. On December 2, 2009, this Court entered an order (ECF No. 4586) establishing February 1, 2010 as the deadline for each person or entity to file a proof of claim in the REALM/ENCORE Debtors’ cases (except governmental units, as defined in section 101(27) of the Bankruptcy Code, for which the Court established April 16, 2010 as the deadline to file proofs of claim).

8. On March 29, 2011, this Court entered an order confirming the Plan (ECF No. 9941). Section 6.2 of the Plan provides for the creation of the GUC Trust to administer certain responsibilities after the Effective Date (as defined in the Plan), including resolving outstanding Disputed General Unsecured Claims (as defined in the Plan). All conditions to the occurrence of the Effective Date were met or waived on March 31, 2011, thereby making the Plan effective as of that date.

The Settlement Agreement

9. Pursuant to the Original Settlement Agreement, entered into initially by General Motors Corporation, the IUE-CWA, the Industrial Division of the Communications Workers of America, AFL-CIO, CLC, and the United Steel, Paper and Forestry, Rubber, Manufacturing, Energy, Allied Industrial and Service Workers International Union, AFL-CIO, CLC, New GM agreed to provide certain retiree medical benefits at a reduced level to participating union retirees and surviving spouses who are not eligible for Medicare benefits. New GM also agreed to provide a reduced level of life insurance coverage to participating retirees (regardless of Medicare eligibility). The Original Settlement Agreement further provided that with respect to those retirees who were eligible for Medicare as of December 31, 2009, MLC granted to unions that agreed to the applicable terms of, and agreed to participate in, the Original Settlement Agreement (the “**Splinter Unions**”), a prepetition, general unsecured claim in these chapter 11 cases in an amount equal to such union’s respective “Percentage Share” of the aggregate amount of \$1 billion (the “**Allowed Claim**”). The Allowed Claim is in full settlement, satisfaction, and discharge of all claims that the Splinter Unions, as authorized section 1114 and 1113 representatives, have or may have against the Debtors and their affiliates arising out of collective bargaining agreements relating to retiree healthcare benefits, life insurance benefits, and all other benefits and claims.

10. The Original Settlement Agreement⁵ provides at Paragraph 10 (*Waiver and Release*) that all employment- and employee benefits-related claims by the Splinter Union Employees are waived as against MLC:

⁵ Subsequent to this Court’s approval of the Original Settlement Agreement, and as contemplated therein, the following additional splinter unions agreed to be bound by the terms of the Original Settlement Agreement on behalf of their members through the following supplemental agreements (the “**Supplemental Agreements**”): International Association of Machinists and Aerospace Workers (June 28, 2010); International Brotherhood of Electrical Workers (November 2, 2009); Michigan Regional Council of Carpenters, Local 687 and Interior Systems, Local 1045 (November 4, 2009); International Brotherhood of Painters and Allied Trades of the United States and Canada, Sign & Display Union Local 39 (November 4, 2009); the International Brotherhood of Teamsters (June 25, 2010); the

Other than as set forth in paragraph 3 with respect to the Allowed Claim, the IUE-CWA and USW as authorized Bankruptcy Code section 1114 and 1113 representatives withdraw with prejudice all claims filed or otherwise made against GM or MLC and their subsidiaries and their employees, officers, directors and agents, relating to retiree health care benefits and basic life insurance and pursuant to any GM-IUE-CWA and GM-USW collective bargaining Agreements or otherwise, and agree not to bring any such claims in the future, and furthermore, on their own behalf and on behalf of all represented members/retirees, release and forever discharge MLC, and its current or former officers, directors, employees, agents, subsidiaries, affiliates and any and all of its welfare and pension benefit plans and their fiduciaries, with respect to any and all rights, claims or causes of action that any of them have or hereafter may have, whether known or unknown, suspected or unsuspected, concealed or hidden, arising out of, based upon or otherwise related to any claim arising out of their employment with MLC, including, without limitation, alleged breaches of a collective bargaining agreement, the Combs Settlement, any alleged entitlement to health care in retirement, and any alleged entitlement to life insurance in retirement.

11. The IUE-CWA has specifically acted as a representative of the Splinter Union Employee pursuant to sections 1113 and 1114 of the Bankruptcy Code in reaching agreement with the Debtors.⁶ As the Splinter Union Employee Claim asserts a claim arising out of the Splinter Union Employee's employment with MLC, such claim against the Debtors (and, consequently, the GUC Trust) has been extinguished pursuant to Paragraph 10 of the Settlement Agreement, as described above. As a result, neither the Debtors nor the GUC Trust have any liability to the Splinter Union Employee relating to Splinter Union Employee Claim.

International Union of Operating Engineers, Locals 101S, 832(S) and 18(S) (November 4, 2009); and the United Catering Restaurant Bar & Hotel Workers (November 2, 2009).

⁶ The sole remaining splinter union, the International Brotherhood of Boilermakers (the "**IBB**"), declined to represent its retired past members (the "**IBB Retirees**") and did not agree to participate in the Original Settlement Agreement, nor has New GM assumed any liability for any claims attributable to the IBB Retirees. Rather than terminate the health and life insurance benefits of these IBB Retirees, by motion dated February 8, 2011 (ECF No. 9121), the Debtors requested that the Court authorize the Debtors, in conjunction with New GM, to provide the IBB Retirees the health and life insurance benefits on essentially the same terms and conditions provided to the other retirees as provided for in the Splinter Union Settlement. On March 9, 2011, the Court entered an order approving the addition of the IBB Retirees as parties to the Splinter Union Settlement. The Splinter Union Employee is not an IBB Retiree.

The Relief Requested Should Be Approved by the Court

12. A filed proof of claim is “deemed allowed, unless a party in interest . . . objects.” 11 U.S.C. § 502(a). If an objection refuting at least one of the claim’s essential allegations is asserted, the claimant has the burden to demonstrate the validity of the claim. *See In re Oneida, Ltd.*, 400 B.R. 384, 389 (Bankr. S.D.N.Y. 2009), *aff’d*, No. 09 Civ. 2229, 2010 WL 234827 (S.D.N.Y. Jan. 22, 2010); *In re Adelphia Commc’ns Corp.*, No. 02-41729, 2007 Bankr. LEXIS 660, at *15 (Bankr. S.D.N.Y. Feb. 20, 2007); *In re Rockefeller Ctr. Props.*, 272 B.R. 524, 539 (Bankr. S.D.N.Y. 2000).

13. Section 502(b)(1) of the Bankruptcy Code provides, in relevant part, that a claim may not be allowed to the extent that “such claim is unenforceable against the debtor and property of the debtor, under any agreement or applicable law.” 11 U.S.C. § 502(b)(1). The Debtors and the GUC Trust have examined the terms of the Settlement Agreement and compared it with the proof of claim identified on Exhibit “A” and have determined that the Splinter Union Employee Claim is not the responsibility of MLC, the Debtors, or the GUC Trust, having been settled by the Settlement Agreement as described herein, or otherwise assumed by New GM. New GM has also acknowledged this to be the case.

14. The Splinter Union Employee Claim was filed by a Splinter Union Employee covered under the Settlement Agreement. To avoid the possibility of multiple recoveries by the same claimant, the GUC Trust requests that the Court disallow and expunge in their entirety the Splinter Union Employee Claim from the claims register.

Notice

15. Notice of this Objection to Claim has been provided to the claimant listed on the proof of claim at Exhibit “A” hereto and parties in interest in accordance with the Sixth Amended Order Pursuant to 11 U.S.C. § 105(a) and Fed. R. Bankr. P. 1015(c) and 9007

Establishing Notice and Case Management Procedures, dated May 5, 2011 (ECF No. 10183).

The GUC Trust submits that such notice is sufficient and no other or further notice need be provided.

16. No previous request for the relief sought herein has been made by the GUC Trust to this or any other Court.

Conclusion

WHEREFORE the GUC Trust respectfully requests entry of an order granting the relief requested herein and such other and further relief as is just.

Dated: New York, New York
September 14, 2012

/s/ Joseph H. Smolinsky

Harvey R. Miller

Stephen Karotkin

Joseph H. Smolinsky

WEIL, GOTSHAL & MANGES LLP

767 Fifth Avenue

New York, New York 10153

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Attorneys for Motors Liquidation
Company GUC Trust

**UNITED STATES BANKRUPTCY COURT
SOUTHERN DISTRICT OF NEW YORK**

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In re	:	Chapter 11 Case No.
	:	
MOTORS LIQUIDATION COMPANY, <i>et al.</i> ,	:	09-50026 (REG)
f/k/a General Motors Corp., <i>et al.</i>	:	
	:	
Debtors.	:	(Jointly Administered)
	:	
-----X		

**ORDER GRANTING OBJECTION TO
PROOF OF CLAIM 28560 FILED BY ALICIA E. CALHOUN
(Splinter Union Employee Claim)**

Upon the objection to expunge proof of claim 28560 filed by Alicia E. Calhoun, a former employee of the Debtors represented by the IUE-CWA union, dated September 14, 2012 (the “**Objection to Claim**”),¹ of the Motors Liquidation Company GUC Trust (the “**GUC Trust**”), formed by the above-captioned debtors (collectively, the “**Debtors**”) in connection with the Debtors’ Second Amended Joint Chapter 11 Plan, dated March 18, 2011 (as may be amended, supplemented, or modified from time to time, the “**Plan**”), pursuant to section 502(b) of title 11, United States Code (the “**Bankruptcy Code**”), Rule 3007 of the Federal Rules of Bankruptcy Procedure (the “**Bankruptcy Rules**”), seeking entry of an order disallowing and expunging the Splinter Union Employee Claim on the ground that the claim is for an obligation for which the Debtors and the GUC Trust have no liability, all as more fully described in the Objection to Claim; and due and proper notice of the Objection to Claim having been provided, and it appearing that no other or further notice need be provided; and the Court having found and determined that the relief sought in the Objection to Claim is in the best interests of the Debtors,

¹ Capitalized terms used herein and not otherwise defined herein shall have the meanings ascribed to such terms in the Objection to Claim.

their estates, the GUC Trust, creditors, and all parties in interest and that the legal and factual bases set forth in the Objection to Claim establish just cause for the relief granted herein; and after due deliberation and sufficient cause appearing therefor, it is

ORDERED that the relief requested in the Objection to Claim is granted to the extent provided herein; and it is further

ORDERED that, pursuant to section 502(b) of the Bankruptcy Code, Proof of Claim 28560 filed by Alicia E. Calhoun (the “**Splinter Union Employee Claim**”) is hereby disallowed and expunged from the claims registry; and it is further

ORDERED that this Order has no res judicata, estoppel, or other effect on the validity, allowance, or disallowance of, and all rights to object on any basis are expressly reserved with respect to the Splinter Union Employee Claim; and it is further

ORDERED that this Court shall retain jurisdiction to hear and determine all matters arising from or related to this Order.

Dated: New York, New York
_____, 2012

United States Bankruptcy Judge

ANNEX A

03700581

Pg 16 of 57

APS0711866317

UNITED STATES BANKRUPTCY COURT FOR THE SOUTHERN DISTRICT OF NEW YORK

PROOF OF CLAIM

Name of Debtor (Check Only One)
☒ Motors Liquidation Company (f/k/a General Motors Corporation)
☐ MLCS, LLC (f/k/a Saturn, LLC)
☐ MLCS Distribution Corporation (f/k/a Saturn Distribution Corporation)
☐ MLC of Harlem, Inc. (f/k/a Chevrolet-Saturn of Harlem, Inc.)

Case No
 09-50026 (REG)
 09-50027 (REG)
 09-50028 (REG)
 09-13558 (REG)

NOT: This form should not be used to make a claim for an administrative expense arising after the commencement of the case but may be used for purposes of asserting a claim under 11 U.S.C. § 503(b)(9) (see Item # 5). All other requests for payment of an administrative expense should be filed pursuant to 11 U.S.C. § 503.

Name of Creditor (the person or other entity to whom the debtor owes money or property) ALLICIA E CALHOUN

Name and address where notices should be sent

ALLICIA E CALHOUN
 14330 58TH ST N APT 8103
 CLEARWATER, FL 33760-2826

☐ Check this box to indicate that this claim amends a previously filed claim

Court Claim Number _____
 (If known)

Filed on _____

Telephone number

727-474-5713

Email Address

alliciaealhoun@yahoo.com

Name and address where payment should be sent (if different from above)

FILED - 28560
 MOTORS LIQUIDATION COMPANY
 F/K/A GENERAL MOTORS CORP
 SDNY # 09-50026 (REG)

☐ Check this box if you are aware that anyone else has filed a proof of claim relating to your claim. Attach copy of statement giving particulars

☐ Check this box if you are the debtor or trustee in this case

Telephone number

Your Claim is Scheduled As Follows.



If in amount is identified above you have a claim scheduled by one of the Debtors as shown. (This scheduled amount of your claim may be an amendment to a previously scheduled amount.) If you agree with the amount and priority of your claim as scheduled by the Debtor and you have no other claim against the Debtor you do not need to file this proof of claim form, EXCEPT AS LOANS. If the amount shown is listed as DISPUTED, UNLIQUIDATED, or CONTINGENT, a proof of claim MUST be filed in order to receive any distribution in respect of your claim. If you have already filed a proof of claim in accordance with the attached instructions, you need not file again.

1 Amount of Claim as of Date Case Filed, June 1, 2009

\$ 346,000.00

If all or part of your claim is secured, complete item 4 below, however, if all of your claim is unsecured, do not complete item 4. If all or part of your claim is entitled to priority, complete item 5. If all or part of your claim is asserted pursuant to 11 U.S.C. § 503(b)(9), complete item 5.

☐ Check this box if claim includes interest or other charges in addition to the principal amount of claim. Attach itemized statement of interest or charges.

2 Basis for Claim Loss of wages, Terminated

(See instruction #2 on reverse side)

3 Last four digits of any number by which creditor identifies debtor 6461

3a Debtor may have scheduled account as

(See instruction #3a on reverse side)

4 Secured Claim (See instruction #4 on reverse side)

Check the appropriate box if your claim is secured by a lien on property or a right of setoff and provide the requested information.

Nature of property or right of setoff ☐ Real Estate ☐ Motor Vehicle ☐ Equipment ☐ Other Describe

Value of Property \$ _____ Annual Interest Rate %

Amount of arrearage and other charges as of time case filed included in secured claim, if any \$ _____

Basis for perfection _____

Amount of Secured Claim \$ _____ Amount Unsecured \$ _____

6 Credits The amount of all payments on this claim has been credited for the purpose of making this proof of claim

7 Documents Attach redacted copies of any documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements or running accounts, contracts, judgments, mortgages, and security agreements. You may also attach a summary. Attach redacted copies of documents providing evidence of perfection of a security interest. You may also attach a summary. (See instruction 7 and definition of "redacted" on reverse side)

DO NOT SEND ORIGINAL DOCUMENTS ATTACHED DOCUMENTS MAY BE DESTROYED AFTER SCANNING

If the documents are not available, please explain in an attachment

5 Amount of Claim Entitled to Priority under 11 U.S.C. § 507(a) If any portion of your claim falls in one of the following categories, check the box and state the amount

Specify the priority of the claim

☐ Domestic support obligations under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B)

☒ Wages, salaries, or commissions (up to \$10,950*) earned within 180 days before filing of the bankruptcy petition or cessation of the debtor's business, whichever is earlier - 11 U.S.C. § 507(a)(4)

☐ Contributions to an employee benefit plan - 11 U.S.C. § 507(a)(5)

☐ Up to \$2,425* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use - 11 U.S.C. § 507(a)(7)

☐ Taxes or penalties owed to governmental units - 11 U.S.C. § 507(a)(8)

☐ Value of goods received by the Debtor within 20 days before the date of commencement of the case - 11 U.S.C. § 507(b)(9) (§ 507(a)(2))

☐ Other - Specify applicable paragraph of 11 U.S.C. § 507(a)()

Amount entitled to priority

\$ 346,000.00

*Amounts are subject to adjustment on 4/1/10 and every 3 years thereafter with respect to cases commenced on or after the date of adjustment

Date 11/13/09 Signature The person filing this claim must sign it. Sign and print name and title, if any, of the creditor or other person authorized to file this claim and state address and telephone number if different from the notice address above. Attach copy of power of attorney, if any.

Allicia E. Calhoun

FOR COURT USE ONLY

INSTRUCTIONS FOR PROOF OF CLAIM FORM

The instructions and definitions below are general explanations of the law. In certain circumstances, such as bankruptcy cases not filed voluntarily by the debtor, there may be exceptions to these general rules. The attorneys for the Debtors and their court-appointed claims agent, The Garden City Group, Inc., are not authorized and are not providing you with any legal advice.

A SEPARATE PROOF OF CLAIM FORM MUST BE FILED AGAINST EACH DEBTOR

PLEASE SEND YOUR ORIGINAL, COMPLETED CLAIM FORM AS FOLLOWS: **IF BY MAIL**, THE GARDEN CITY GROUP, INC., ATTN: MOTORS LIQUIDATION COMPANY CLAIMS PROCESSING, P.O. BOX 9386, DUBLIN, OH 43017-4286. **IF BY HAND OR OVERNIGHT COURIER**, THE GARDEN CITY GROUP, INC., ATTN: MOTORS LIQUIDATION COMPANY CLAIMS PROCESSING, 5151 BLAZER PARKWAY, SUITE A, DUBLIN, OH 43017. PROOFS OF CLAIM MAY ALSO BE HAND DELIVERED TO THE UNITED STATES BANKRUPTCY COURT, SDNY, ONE BOWLING GREEN, ROOM 534, NEW YORK, NEW YORK 10004. **ANY PROOF OF CLAIM SUBMITTED BY FACSIMILE OR E-MAIL WILL NOT BE ACCEPTED.**

THE GENERAL AND GOVERNMENTAL BAR DATE IS NOVEMBER 30, 2009 AT 5 00 P.M. (PREVAILING EASTERN TIME)

Court, Name of Debtor, and Case Number

These Chapter 11 cases were commenced in the United States Bankruptcy Court for the Southern District of New York on June 1, 2009. You should select the debtor against which you are asserting your claim.

A SEPARATE PROOF OF CLAIM FORM MUST BE FILED AGAINST EACH DEBTOR

Creditor's Name and Address

Fill in the name of the person or entity asserting a claim and the name and address of the person who should receive notices issued during the bankruptcy case. Please provide us with a valid email address. A separate space is provided for the payment address if it differs from the notice address. The creditor has a continuing obligation to keep the court informed of its current address. See Federal Rule of Bankruptcy Procedure (FRBP) 2002(g).

1. Amount of Claim as of Date Case Filed

State the total amount owed to the creditor on the date of the bankruptcy filing. Follow the instructions concerning whether to complete items 4 and 5. Check the box if interest or other charges are included in the claim.

2. Basis for Claim

State the type of debt or how it was incurred. Examples include: goods sold, money loaned, services performed, personal injury/wrongful death, car loan, mortgage note, and credit card. If the claim is based on the delivery of health care goods or services, limit the disclosure of the goods or services so as to avoid embarrassment or the disclosure of confidential health care information. You may be required to provide additional disclosure if the debtor, trustee or another party in interest files an objection to your claim.

3. Last Four Digits of Any Number by Which Creditor Identifies Debtor

State only the last four digits of the debtor's account or other number used by the creditor to identify the debtor, if any.

3a. Debtor May Have Scheduled Account As

Use this space to report a change in the creditor's name, a transferred claim, or any other information that clarifies a difference between this proof of claim and the claim as scheduled by the debtor.

4. Secured Claim

Check the appropriate box and provide the requested information if the claim is fully or partially secured. Skip this section if the claim is entirely unsecured. (See DEFINITIONS, below.) State the type and the value of property that secures the claim, attach copies of lien documentation, and state annual interest rate and the amount past due on the claim as of the date of the bankruptcy filing.

5. Amount of Claim Entitled to Priority Under 11 U.S.C. § 507(a)

If any portion of your claim falls in one or more of the listed categories, check the appropriate box(es) and state the amount entitled to priority. (See DEFINITIONS, below.) A claim may be partly priority and partly non-priority. For example, in some of the categories, the law limits the amount entitled to priority.

For claims pursuant to 11 U.S.C. § 503(b)(9), indicate the amount of your claim arising from the value of any goods received by the debtor within 20 days before June 1, 2009, the date of commencement of these cases. (See DEFINITIONS, below.) Attach documentation supporting such claim.

6. Credits

An authorized signature on this proof of claim serves as an acknowledgment that when calculating the amount of the claim, the creditor gave the Debtor credit for any payments received toward the debt.

7. Documents

Attach to this proof of claim form redacted copies documenting the existence of the debt and of any lien securing the debt. You may also attach a summary. You must also attach copies of documents that evidence perfection of any security interest. You may also attach a summary FRBP 3001(c) and (d). If the claim is based on the delivery of health care goods or services, see instruction 2. Do not send original documents, as attachments may be destroyed after scanning.

Date and Signature

The person filing this proof of claim must sign and date it. FRBP 9011. If the claim is filed electronically, FRBP 5005(a)(2) authorizes courts to establish local rules specifying what constitutes a signature. Print the name and title, if any, of the creditor or other person authorized to file this claim. State the filer's address and telephone number if it differs from the address given on the top of the form for purposes of receiving notices. Attach a complete copy of any power of attorney. Criminal penalties apply for making a false statement on a proof of claim.

DEFINITIONS

Debtor

A debtor is the person, corporation, or other entity that has filed a bankruptcy case. The Debtors in these Chapter 11 cases are:

Motors Liquidation Company (f/k/a General Motors Corporation)	09-50026 (REG)
MLCS, LLC (f/k/a Saturn, LLC)	09-50027 (REG)
MLCS Distribution Corporation (f/k/a Saturn Distribution Corporation)	09-50028 (REG)
MLC of Harlem, Inc. (f/k/a Chevrolet-Saturn of Harlem, Inc.)	09-13558 (RLG)

Creditor

A creditor is the person, corporation, or other entity owed a debt by the debtor on the date of the bankruptcy filing.

Claim

A claim is the creditor's right to receive payment on a debt that was owed by the Debtor on the date of the bankruptcy filing. See 11 U.S.C. § 101(5). A claim may be secured or unsecured.

Proof of Claim

A proof of claim is a form used by the creditor to indicate the amount of the debt owed by the debtor on the date of the bankruptcy filing. The creditor must file the form with The Garden City Group, Inc. as described in the instructions above and in the Bar Date Notice.

Secured Claim Under 11 U.S.C. § 506(a)

A secured claim is one backed by a lien on property of the debtor. The claim is secured so long as the creditor has the right to be

paid from the property prior to other creditors. The amount of the secured claim cannot exceed the value of the property. Any amount owed to the creditor in excess of the value of the property is an unsecured claim. Examples of liens on property include a mortgage on real estate or a security interest in a car. A lien may be voluntarily granted by a debtor or may be obtained through a court proceeding. In some states, a court judgment is a lien. A claim also may be secured if the creditor owes the debtor money (has a right to setoff).

Section 503(b)(9) Claim

A Section 503(b)(9) claim is a claim for the value of any goods received by the debtor within 20 days before the date of commencement of a bankruptcy case in which the goods have been sold to the debtor in the ordinary course of such debtor's business.

Unsecured Claim

An unsecured claim is one that does not meet the requirements of a secured claim. A claim may be partly unsecured if the amount of the claim exceeds the value of the property on which the creditor has a lien.

Claim Entitled to Priority Under 11 U.S.C. § 507(a)

Priority claims are certain categories of unsecured claims that are paid from the available money or property in a bankruptcy case before other unsecured claims.

Redacted

A document has been redacted when the person filing it has masked, edited out, or otherwise deleted, certain information. A creditor should redact and use only the last four digits of any social-security, individual's

tax-identification, or financial-account number, all but the initials of a minor's name and only the year of any person's date of birth.

Evidence of Perfection

Evidence of perfection may include a mortgage, lien, certificate of title, financing statement, or other document showing that the lien has been filed or recorded.

Acknowledgment of Filing of Claim

To receive acknowledgment of your filing from The Garden City Group, Inc., please provide a self-addressed, stamped envelope and a copy of this proof of claim when you submit the original claim to The Garden City Group, Inc.

Offers to Purchase a Claim

Certain entities are in the business of purchasing claims for an amount less than the face value of the claims. One or more of these entities may contact the creditor and offer to purchase the claim. Some of the written communications from these entities may easily be confused with official court documentation or communications from the debtor. These entities do not represent the bankruptcy court or the debtor. The creditor has no obligation to sell its claim. However, if the creditor decides to sell its claim, any transfer of such claim is subject to FRBP 3001(e), any applicable provisions of the Bankruptcy Code (11 U.S.C. § 101 et seq.), and any applicable orders of the bankruptcy court.

Additional Information

If you have any questions with respect to this claim form, please contact Alix Partners at 1 (800) 414-9607 or by e-mail at claims@motorliquidation.com.



General Motors Truck Group

This proof of claim is for lost wages. I took a leave of absence in April 2002. After the death of my Father, I could not get the union or the company to provide me with the documentation I needed to take a leave for schooling. Linda Hodgson in the office, assisted me, with the paper work and told me to get enrolled in school, which I did, then they terminated me.

CERTIFIED MAIL

April 26, 2002

A. Calhoun
727-474-5713
727-692-2122

• Belucia Calhoun
• 111 Grafton Ave. #111
• Clayton, OK 45406
• Mrs Calhoun:

Your seniority has been terminated in accordance with the provisions of Paragraph 34(d) of the GM-IUE National Agreement as of the end of the shift on Monday, 4-22-2002

Sincerely,

Linda Hodgson
Hourly Employment
Moraine Assembly Plant
(937) 455-2878

CC: R. Cross

Labor Relations

Pension

Sandy Schmitt - Benefits

Medical

Payroll

Supv. -

LDW -

file

Calhoun (RGG) 2
4-3-2002

288-64-6461

3700581

Largo , Florida
10/13/10

Weil, Gotshal & Manges LLP
767 Fifth Ave
New York, New York 10153

Claim # 28560	25,000 Yr 2002
Settlement offer	60,000 Yr 2003
	<u>75,000 Yr 2004</u>
	160,000 Income for 10 yrs service approximate
	100,000 Severance- Lose of company Bankruptcy

I was retired by GM in 2003 Seven months after I took a leave of absence, because of my ongoing battles with depression and misuse of prescription drugs
I filed for disability with social security in January of 2004 Also seeking compensation for lost benefits which I would be entitled to as a retired worker with a pension Original claim was for US\$346,000 00

03700581

APS0711866317



UNITED STATES BANKRUPTCY COURT FOR THE SOUTHERN DISTRICT OF NEW YORK

PROOF OF CLAIM

Name of Debtor (Check Only One)
☒ Motors Liquidation Company (f/k/a General Motors Corporation)
☐ MLCS, LLC (f/k/a Saturn, LLC)
☐ MLCS Distribution Corporation (f/k/a Saturn Distribution Corporation)
☐ MLC of Harlem, Inc (f/k/a Chevrolet-Saturn of Harlem, Inc)

Case No
 09-50026 (REG)
 09-50027 (REG)
 09-50028 (REG)
 09-13558 (REG)

NOTE: This form should not be used to make a claim for an administrative expense arising after the commencement of the case but may be used for purposes of asserting a claim under 11 U.S.C. § 503(b)(9) (see item # 3). All other requests for payment of an administrative expense should be filed pursuant to 11 U.S.C. § 503.

Name of Creditor (the person or other entity to whom the debtor owes money or property) ALLICIA E CALHOUN

Name and address where notices should be sent

ALLICIA E CALHOUN
 14330 58TH ST N APT 8103
 CLEARWATER, FL 33760-2826

☐ Check this box to indicate that this claim amends a previously filed claim

Court Claim Number _____
 (If known)

Filed on _____

Telephone number

Email Address

727-474-5713
 alliciae@allucan.com

Name and address where payment should be sent (if different from above)

☐ Check this box if you are aware that anyone else has filed a proof of claim relating to your claim. Attach copy of statement giving particulars

☐ Check this box if you are the debtor or trustee in this case

Telephone number

Amount of Claim as of Date Case Filed, June 1, 2009

\$ 346,000.00

all or part of your claim is secured, complete item 4 below; however, if all of your claim is unsecured, do not complete item 4. If all or part of your claim is entitled to priority, complete item 5. If all or part of your claim is asserted pursuant to 11 U.S.C. § 503(b)(9), complete item 5.

☐ Check this box if claim includes interest or other charges in addition to the principal amount of claim. Attach itemized statement of interest or charges

Basis for Claim loss of income/wages, terminated
 (See instruction #2 on reverse side)

Last four digits of any number by which creditor identifies debtor

3a Debtor may have scheduled account as _____
 (See instruction #3a on reverse side)

Secured Claim (See instruction #4 on reverse side)

Check the appropriate box if your claim is secured by a lien on property or a right of setoff and provide the requested information

Nature of property or right of setoff ☐ Real Estate ☐ Motor Vehicle ☐ Equipment ☐ Other Describe

Value of Property \$ _____ Annual Interest Rate %

Amount of arrearage and other charges as of time case filed included in secured claim, if any \$ _____

Basis for perfection: _____

Amount of Secured Claim \$ _____ Amount Unsecured \$ _____

Credits The amount of all payments on this claim has been credited for the purpose of making this proof of claim

Documents Attach redacted copies of any documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements or running accounts, contracts, judgments, mortgages, and security agreements. You may also attach a summary. Attach redacted copies of documents providing evidence of perfection of security interest. You may also attach a summary. (See instruction 7 and definition of redacted on reverse side)

NOT SEND ORIGINAL DOCUMENTS. ATTACHED DOCUMENTS MAY BE DESTROYED AFTER ANNOUNCING

If documents are not available, please explain in an attachment

Your Claim is Scheduled As Follows.



If an amount is identified above, you have a claim scheduled by one of the Debtors as shown. (This scheduled amount of your claim may be an amendment to a previously scheduled amount.) If you agree with the amount and priority of your claim as scheduled by the Debtor and you have no other claim against the Debtor, you do not need to file this proof of claim form, EXCEPT AS FOLLOWS. If the amount shown is listed as DISPUTED, UNLIQUIDATED, or CONTINGENT, a proof of claim MUST be filed in order to receive any distribution in respect of your claim. If you have already filed a proof of claim in accordance with the attached instructions, you need not file again.

5 Amount of Claim Entitled to Priority under 11 U.S.C. § 507(a). If any portion of your claim falls in one of the following categories, check the box and state the amount

Specify the priority of the claim

- ☐ Domestic support obligations under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B)
- ☒ Wages, salaries, or commissions (up to \$10,950*) earned within 180 days before filing of the bankruptcy petition or cessation of the debtor's business, whichever is earlier - 11 U.S.C. § 507(a)(4)
- ☐ Contributions to an employee benefit plan - 11 U.S.C. § 507(a)(5)
- ☐ Up to \$2,425* of deposits toward purchase, lease, or rental of property or services for personal family or household use - 11 U.S.C. § 507(a)(7)
- ☐ Taxes or penalties owed to governmental units - 11 U.S.C. § 507(a)(8)
- ☐ Value of goods received by the Debtor within 20 days before the date of commencement of the case - 11 U.S.C. § 503(b)(9) (§ 507(a)(2))
- ☐ Other - Specify applicable paragraph of 11 U.S.C. § 507(a)()

Amount entitled to priority

\$ 346,000.00

*Amounts are subject to adjustment on 4/1/10 and every 3 years thereafter with respect to cases commenced on or after the date of adjustment

Signature The person filing this claim must sign it. Sign and print name and title, if any, of the creditor or other person authorized to file this claim and state address and telephone number if different from the notice address above. Attach copy of power of attorney, if any

Date 11/13/09

Allicia E. Calhoun

FOR COURT USE ONLY

INSTRUCTIONS FOR PROOF OF CLAIM FORM

The instructions and definitions below are general explanations of the law. In certain circumstances, such as bankruptcy cases not filed voluntarily by the debtor, there may be exceptions to these general rules. The attorneys for the Debtors and their court appointed claims agent, The Garden City Group, Inc., are not authorized and are not providing you with any legal advice.

A SEPARATE PROOF OF CLAIM FORM MUST BE FILED AGAINST EACH DEBTOR

PLEASE SEND YOUR ORIGINAL, COMPLETED CLAIM FORM AS FOLLOWS: IF BY MAIL, THE GARDEN CITY GROUP, INC., ATTN: MOTORS LIQUIDATION COMPANY, CLAIMS PROCESSING, P.O. BOX 9366, DUBLIN, OH 43017-4286; IF BY HAND OR OVERNIGHT COURIER, THE GARDEN CITY GROUP, INC., ATTN: MOTORS LIQUIDATION COMPANY, CLAIMS PROCESSING, 5151 BLAZER PARKWAY, SUITE A, DUBLIN, OH 43017. PROOFS OF CLAIM MAY ALSO BE HAND DELIVERED TO THE UNITED STATES BANKRUPTCY COURT, SDNY, ONE BOWLING GREEN, ROOM 534, NEW YORK, NEW YORK 10004. ANY PROOF OF CLAIM SUBMITTED BY FACSIMILE OR E-MAIL WILL NOT BE ACCEPTED.

THE GENERAL AND GOVERNMENTAL BAR DATE IS NOVEMBER 30, 2009 AT 5:00 P.M. (PREVAILING EASTERN TIME)

Court, Name of Debtor, and Case Number

These Chapter 11 cases were commenced in the United States Bankruptcy Court for the Southern District of New York on June 1, 2009. You should select the debtor against which you are asserting your claim.

A SEPARATE PROOF OF CLAIM FORM MUST BE FILED AGAINST EACH DEBTOR

Creditor's Name and Address

Fill in the name of the person or entity asserting a claim and the name and address of the person who should receive notices issued during the bankruptcy case. Please provide us with a valid email address. A separate space is provided for the payment address if it differs from the notice address. The creditor has a continuing obligation to keep the court informed of its current address. See Federal Rule of Bankruptcy Procedure (FRBP) 2002(g).

1. Amount of Claim as of Date Case Filed

State the total amount owed to the creditor on the date of the bankruptcy filing. Follow the instructions concerning whether to complete items 4 and 5. Check the box if interest or other charges are included in the claim.

2. Basis for Claim

State the type of debt or how it was incurred. Examples include goods sold, money loaned, services performed, personal injury/wrongful death, car loan, mortgage note, and credit card. If the claim is based on the delivery of health care goods or services, limit the disclosure of the goods or services so as to avoid embarrassment or the disclosure of confidential health care information. You may be required to provide additional disclosure if the debtor, trustee or another party in interest files an objection to your claim.

3. Last Four Digits of Any Number by Which Creditor Identifies Debtor

State only the last four digits of the debtor's account or other number used by the creditor to identify the debtor, if any.

3a. Debtor May Have Scheduled Account As

Use this space to report a change in the creditor's name, a transferred claim, or any other information that clarifies a difference between this proof of claim and the claim as scheduled by the debtor.

4. Secured Claim

Check the appropriate box and provide the requested information if the claim is fully or partially secured. Skip this section if the claim is entirely unsecured. (See DEFINITIONS, below.) State the type and the value of property that secures the claim, attach copies of lien documentation, and state annual interest rate and the amount past due on the claim as of the date of the bankruptcy filing.

5. Amount of Claim Entitled to Priority Under 11 U.S.C. § 507(a)

If any portion of your claim falls in one or more of the listed categories, check the appropriate box(es) and state the amount entitled to priority. (See DEFINITIONS, below.) A claim may be partly priority and partly non-priority. For example, in some of the categories, the law limits the amount entitled to priority.

For claims pursuant to 11 U.S.C. § 503(b)(9), indicate the amount of your claim arising from the value of any goods received by the debtor within 20 days before June 1, 2009, the date of commencement of these cases. (See DEFINITIONS, below.) Attach documentation supporting such claim.

6. Credits

An authorized signature on this proof of claim serves as an acknowledgment that when calculating the amount of the claim, the creditor gave the Debtor credit for any payments received toward the debt.

7. Documents

Attach to this proof of claim form redacted copies documenting the existence of the debt and of any lien securing the debt. You may also attach a summary. You must also attach copies of documents that evidence perfection of any security interest. You may also attach a summary FRBP 3001(c) and (d). If the claim is based on the delivery of health care goods or services, see instruction 2. Do not send original documents, as attachments may be destroyed after scanning.

Date and Signature

The person filing this proof of claim must sign and date it. FRBP 9011. If the claim is filed electronically, FRBP 5005(a)(2) authorizes courts to establish local rules specifying what constitutes a signature. Print the name and title, if any, of the creditor or other person authorized to file this claim. State the filer's address and telephone number if it differs from the address given on the top of the form for purposes of receiving notices. Attach a complete copy of any power of attorney. Criminal penalties apply for making a false statement or a proof of claim.

DEFINITIONS

Debtor

A debtor is the person, corporation, or other entity that has filed a bankruptcy case. The Debtors in these Chapter 11 cases are:

Motors Liquidation Company (f/k/a General Motors Corporation)	09-50026 (REG)
MLCS, LLC (f/k/a Saturn, LLC)	09-50027 (RLG)
MLCS Distribution Corporation (f/k/a Saturn Distribution Corporation)	09-50028 (REG)
MLC of Harlem, Inc. (f/k/a Chevrolet-Saturn of Harlem, Inc.)	09-13558 (REG)

Creditor

A creditor is the person, corporation, or other entity owed a debt by the debtor on the date of the bankruptcy filing.

Claim

A claim is the creditor's right to receive payment on a debt that was owed by the Debtor on the date of the bankruptcy filing. See 11 U.S.C. § 101(5). A claim may be secured or unsecured.

Proof of Claim

A proof of claim is a form used by the creditor to indicate the amount of the debt owed by the debtor on the date of the bankruptcy filing. The creditor must file the form with The Garden City Group, Inc. as described in the instructions above and in the Bar Date Notice.

Secured Claim Under 11 U.S.C. § 506(a)

A secured claim is one backed by a lien on property of the debtor. The claim is secured so long as the creditor has the right to be

paid from the property prior to other creditors. The amount of the secured claim cannot exceed the value of the property. Any amount owed to the creditor in excess of the value of the property is an unsecured claim. Examples of liens on property include a mortgage on real estate or a security interest in a car. A lien may be voluntarily granted by a debtor or may be obtained through a court proceeding. In some states, a court judgment is a lien. A claim also may be secured if the creditor owes the debtor money (has a right to setoff).

Section 503(b)(9) Claim

A Section 503(b)(9) claim is a claim for the value of any goods received by the debtor within 20 days before the date of commencement of a bankruptcy case in which the goods have been sold to the debtor in the ordinary course of such debtor's business.

Unsecured Claim

An unsecured claim is one that does not meet the requirements of a secured claim. A claim may be partly unsecured if the amount of the claim exceeds the value of the property on which the creditor has a lien.

Claim Entitled to Priority Under 11 U.S.C. § 507(a)

Priority claims are certain categories of unsecured claims that are paid from the available money or property in a bankruptcy case before other unsecured claims.

Redacted

A document has been redacted when the person filing it has masked, edited out, or otherwise deleted, certain information. A creditor should redact and use only the last four digits of any social-security, individual's

tax-identification, or financial-account number, all but the initials of a minor's name and only the year of any person's date of birth.

Evidence of Perfection

Evidence of perfection may include a mortgage, lien, certificate of title, financing statement, or other document showing that the lien has been filed or recorded.

Acknowledgment of Filing of Claim

To receive acknowledgment of your filing from The Garden City Group, Inc., please provide a self-addressed, stamped envelope and a copy of this proof of claim when you submit the original claim to The Garden City Group, Inc.

Offers to Purchase a Claim

Certain entities are in the business of purchasing claims for an amount less than the face value of the claims. One or more of these entities may contact the creditor and offer to purchase the claim. Some of the written communications from these entities may easily be confused with official court documentation or communications from the debtor. These entities do not represent the bankruptcy court or the debtor. The creditor has no obligation to sell its claim. However, if the creditor decides to sell its claim, any transfer of such claim is subject to FRBP 3001(e), any applicable provisions of the Bankruptcy Code (11 U.S.C. § 101 et seq.), and any applicable orders of the bankruptcy court.

Additional Information

If you have any questions with respect to this claim form, please contact Alix Partners at 1 (800) 414-9607 or by e-mail at claims@motorsliquidation.com.

Social Security Administration Potential Private Pension Benefit Information

ALLICIA E CALHOUN
2718 WESTCHESTER DR N
CLEARWATER FL 33761

Social Security Number

Name A E CALHOUN

We are writing to tell you that you, or the worker whose Social Security number appears at the top of this form, MAY be entitled to some private pension benefits upon retirement. Also, your family, or the worker's family, may be entitled to retirement or survivor benefits.

These Are Not Social Security Benefits

These potential benefits are NOT Social Security benefits and we do not make any decisions about the payment of these benefits. The following provides some basic information about these private pension benefits.

Information About Pension Benefits

You have, or the worker has, earned pension rights although no longer employed in a job covered by the pension plan. These are called "deferred vested benefits." Private pension plan administrators must provide information about such benefits to us through the Internal Revenue Service. We provide this information about the pension plan when the individual asks for it or when a claim is filed for Social Security benefits.

If You Want to Apply for These Benefits

If you want to apply for these pension benefits or have any questions, you should contact the pension Plan Administrator shown below. Include the 9 digit identification number shown below and a copy of this notice when you write to the Plan Administrator.

Plan Name GENERAL MOTORS EMPLOYEE HOURLY-RATE EMPLOYEES PENSION PLAN	Plan Number 38-0572515-003	
	Identification Number 38-0572515	
	Year Reported 2003	Estimated Amount \$337
Plan Administrator and Address GENERAL MOTORS CORPORATION M/C 482-C16-D25 DETROIT MI 48265-3000	Type of Annuity C	Payment Frequency E
	Units or Shares	Value of Account

IMPORTANT: This is all the information we have. See the other side of this page for an explanation of this information.

For SSA Use Only M03-115-65-005

2005075

Social Security Administration

Potential Private Pension Benefit Information

ALLICIA E CALHOUN
2718 WESTCHESTER DR N
CLEARWATER FL 33761

Social Security Number

Name A E CALHOUN

We are writing to tell you that you, or the worker whose Social Security number appears at the top of this form, MAY be entitled to some private pension benefits upon retirement. Also, your family, or the worker's family, may be entitled to retirement or survivor benefits.

These Are Not Social Security Benefits

These potential benefits are NOT Social Security benefits and we do not make any decisions about the payment of these benefits. The following provides some basic information about these private pension benefits

Information About Pension Benefits

You have, or the worker has, earned pension rights although no longer employed in a job covered by the pension plan. These are called "deferred vested benefits" Private pension plan administrators must provide information about such benefits to us through the Internal Revenue Service. We provide this information about the pension plan when the individual asks for it or when a claim is filed for Social Security benefits.

If You Want to Apply for These Benefits

If you want to apply for these pension benefits or have any questions, you should contact the pension Plan Administrator shown below. Include the 9 digit identification number shown below and a copy of this notice when you write to the Plan Administrator

Plan Name GENERAL MOTORS PERSONAL SAVINGS PLAN FOR HOURLY-RATE EMPLOYEES IN	Plan Number 38-0572515-014	
	Identification Number 38-0572515	
	Year Reported 2003	Estimated Amount
Plan Administrator and Address GENERAL MOTORS CORPORATION AND SUBSIDIARIES PO BOX 300 DETROIT MI 48265-3000	Type of Annuity A	Payment Frequency A
	Units or Shares	Value of Account \$3,447

IMPORTANT: This is all the information we have. See the other side of this page for an explanation of this information

For SSA Use Only M04-014-31-023

2005075

EXPLANATION OF INFORMATION

YEAR REPORTED

This is the year for which the Plan Administrator reported the pension plan information to the Internal Revenue Service

ESTIMATED ACCOUNT

This was the amount that would be paid under the plan then in effect. The actual amount could differ because of later changes in the plan. If you have already received payments from the plan, the amount shown on this notice should be disregarded.

TYPE OF ANNUITY

The code listed identifies the type of annuity to be paid:

- A** A single payment of a lump sum
- B** Annuity payable over a fixed number of years
- C** Life annuity
- D** Life annuity with period certain
- E** Cash refund life annuity
- F** Modified cash refund life annuity
- G** Joint and last survivor annuity
- M** Other (Type of annuity not reported)

PAYMENT FREQUENCY

The code listed shows how often the estimated payments would be made under the plan:

- | | |
|------------------------|---|
| A Lump Sum | E Monthly |
| B Annually | M Other (Payment frequency not reported) |
| C Semi-Annually | |
| D Quarterly | |

UNITS OR SHARES

If the pension amount is based on units or shares, the number of units or shares will be shown. The number of shares will be shown followed by "S".

VALUE OF ACCOUNT

If shown, this indicates the value of the account at the time the worker stopped working under the plan.

WRONG ADDRESS OR COMPLAINTS

If you cannot locate the Plan Administrator at the address shown on this notice, contact your former employer for the current address. If you cannot locate your former employer, check the reference department of your local library or contact your State's corporation commission. This agency should be in the telephone book under State government.

If you have a complaint about the way the private pension plan has handled your claim, contact the local office of the Department of Labor's Pension and Welfare Benefits Administration. If this office is not listed in your telephone directory, write to the Department of Labor, Pension and Welfare Benefits Administration, Room N-5619, 200 Constitution Avenue N.W., Washington, DC 20210.

If you have any other Questions, call us toll free at 1-800-772-1213.

DISABILITY REPORT - ADULT - Form SSA-3368-BK

PLEASE READ ALL OF THIS INFORMATION BEFORE YOU BEGIN
COMPLETING THIS FORM

IF YOU NEED HELP

If you need help with this form, do as much of it as you can, and your interviewer will help you finish it. However, if you have access to the Internet, you may access the Disability Report Form Guide at <http://www.ssa.gov/disability/3368/>

HOW TO COMPLETE THIS FORM

The information that you give us on this form will be used by the office that makes the disability decision on your disability claim. You can help them by completing as much of the form as you can

- Please fill out as much of this form as you can before your interview appointment
- Print or type.
- **DO NOT LEAVE ANSWERS BLANK** If you do not know the answers, or the answer is "none" or "does not apply," please write "don't know," or "none," or "does not apply"
- **IN SECTION 4, PUT INFORMATION ON ONLY ONE DOCTOR/HOSPITAL/CLINIC IN EACH SPACE.**
- Each address should include a ZIP code. Each telephone number should include an area code.
- **DO NOT ASK A DOCTOR OR HOSPITAL TO COMPLETE THE FORM.** However, you can get help from other people, like a friend or family member.
- If your appointment is for an interview by telephone, have the form ready to discuss with us when we call you
- If your appointment is for an interview in our office, bring the completed form with you or mail it ahead of time, if you were told to do so
- When a question refers to "you," "your" or the "Disabled Person," it refers to the person who is applying for disability benefits. If you are filling out the form for someone else, please provide information about him or her
- Be sure to explain an answer if the question asks for an explanation, or if you want to give additional information
- If you need more space to answer any questions or want to tell us more about an answer, please use the "REMARKS" section on Pages 9 and 10, and show the number of the question being answered

ABOUT YOUR MEDICAL RECORDS

If you have any medical records and copies of prescriptions at home for the person who is applying for disability benefits, send them to our office with your completed forms or bring them with you to your interview. Also, bring any prescription bottles with you. If you need the records back, tell us and we will photocopy them and return them to you

YOU DO NOT NEED TO ASK DOCTORS OR HOSPITALS FOR ANY MEDICAL RECORDS THAT YOU DO NOT ALREADY HAVE. With your permission, we will do that for you. The information we ask for on this form tells us to whom we should send a request for medical and other records. If you cannot remember the names and addresses of any of the doctors or hospitals, or the dates of treatment, perhaps you can get this information from the telephone book, or from medical bills, prescriptions and prescription bottles.

Disability Report-Adult-Form SSA-3368-BK

SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0579

**DISABILITY REPORT
ADULT**

For SSA Use Only
Do not write in this box

Related SSN _____

Number Holder _____

SECTION 1- INFORMATION ABOUT THE DISABLED PERSON

A NAME (First, Middle Initial, Last)

ALLICIA E. CALHOUN

B. SOCIAL SECURITY NUMBER

[REDACTED]

C DAYTIME TELEPHONE NUMBER (If you have no number where you can be reached, give us a daytime number where we can leave a message for you)

Area
Code

Number

☐ Your Number

☐ Message Number

☐ None

D Give the name of a friend or relative that we can contact (other than your doctors) who knows about your illnesses, injuries or conditions and can help you with your claim

NAME CARSON DOUGLAS

RELATIONSHIP FRIEND

ADDRESS 1022 DANNER AVE. #B

(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

DAYTON, OHIO 45408

City

State

ZIP

DAYTIME 937 586-0831

PHONE

Area Code

Number

E. What is your height without shoes?

5
feet

53/4
inches

F. What is your weight without shoes?

169
pounds

G Do you have a medical assistance card? (For Example, Medicaid or Medi-Cal) If "YES," show the number here: ☐ YES ☒ NO

H Can you speak English? ☒ YES ☐ NO If "NO," what languages can you speak? _____

If you cannot speak English, is there someone we may contact who speaks English and will give you messages? (If this is the same person as in "D" above show "SAME" here)

NAME _____

RELATIONSHIP _____

ADDRESS _____

(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

City

State

ZIP

DAYTIME
PHONE

Area Code

Number

I. Can you read English? ☒ YES ☐ NO **J. Can you write more than your name in English?** ☒ YES ☐ NO

Disability Report-Adult-Form SSA-3368-BK

SECTION 2
YOUR ILLNESSES, INJURIES OR CONDITIONS AND HOW THEY AFFECT YOU

A What are the illnesses, injuries or conditions that limit your ability to work? *Major Depres*
ANXIETY, hyperventilate, Panic Attacks
Foot injury, deformation of character, discrimination. Diminished
sense of self worth. Constant harassment, No support from family or unit

B How do your illnesses, injuries or conditions limit your ability to work? *Became parano*
The drugs they prescribed worsened my condition to where I would sit
in the house for days at a time. I would call in to work and go see my I
she wasn't any help. I couldn't get any relief or help no matter wh
or where. I turned. The people I did turn to seemed to be my enemies
too at least in my mind. They were trying to poison me.

C. Do your illnesses, injuries or conditions cause you pain ☒ YES ☐ NO
or other symptoms?

D. When did your illnesses, injuries or conditions first bother you?

Month <i>9</i>	Day <i>9</i>	Year <i>97</i>
-------------------	-----------------	-------------------

E. When did you become unable to work because of your illnesses, injuries or conditions?

Month	Day	Year
-------	-----	------

F Have you ever worked?

☒ YES ☐ NO (If "NO," go to Section 4)

G Did you work at any time after the date your illnesses, injuries or conditions first bothered you?

☒ YES ☐ NO

H. If "YES," did your illnesses, injuries or conditions cause you to (check all that apply)

- ☒ work fewer hours? (Explain below)
☒ change your job duties? (Explain below)
☒ make any job-related changes such as your attendance, help needed, or employers?
(Explain below)

I was put on restrictions from my Dr. which GMA did honor. Then they tried to fire me but I was exonerated, for
work stoppage. This is when my p decline began
when I first became mentally challenged. After I hurt in
at work. I felt as if

I Are you working now?

☒ YES ☐ NO *I had been shot or se*

If "NO," when did you stop working?

Month	Day	Year
-------	-----	------

J Why did you stop working?

SECTION 3 - INFORMATION ABOUT YOUR WORK

A. List the kinds of jobs that you have had in the last 15 years that you worked

JOB TITLE (Example, Cook)	TYPE OF BUSINESS (Example, Restaurant)	DATES WORKED (month & year)		HOURS PER DAY	DAYS PER WEEK	RATE OF PAY (Per hour, day, week, month or year)
		From	To			
GIM	Group leader	Oct	Apr 02	10	4	\$ 21.00
BALT Co Bd of Ed	Cafeteria worker	Apr	Sept	4+5	5	\$ 9.00
Kmart	Supervisor	Apr	Sept	8	4	\$ 6.75
NCR	Group leader	Oct	Jan 9	8	5	\$ 13.00
Wright Patt AFB	clerk	Jun	Aug	8	5	\$ 5.00
						\$
						\$

B. Which job did you do the longest? NCR

C. Describe this job. What did you do all day? (If you need more space, write in the "Remarks" section.)

Drive fork/lift, shipping + receiving, pay roll
tore down parts (computer) Supervised 8 people. answered phone

D. In this job, did you.

Use machines, tools or equipment?

☒ YES ☐ NO

Use technical knowledge or skills?

☒ YES ☐ NO

Do any writing, complete reports, or perform duties like this?

☒ YES ☐ NO

E. In this job, how many total hours each day did you:

Walk? 6 Stoop? (Bend down & forward at waist) 0

Handle, grab or grasp big objects? 5

Stand? 2 Kneel? (Bend legs to rest on knees) 0

Reach? 2

Sit? 3 Crouch? (Bend legs & back down & forward) 0

Write, type or handle small objects? 2

Climb? 1 Crawl? (Move on hands & knees) 0

F. Lifting and Carrying (Explain what you lifted, how far you carried it, and how often you did this)

off a truck. to a skid.

G. Check heaviest weight lifted:

☐ Less than 10 lbs ☐ 10 lbs ☒ 20 lbs ☐ 50 lbs ☐ 100 lbs or more ☐ Other

H. Check weight frequently lifted: (By frequently, we mean from 1/3 to 2/3 of the workday)

☒ Less than 10 lbs ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs. or more ☐ Other

I. Did you supervise other people in this job? ☒ YES (Complete items below) ☐ NO (Skip to next page)

How many people did you supervise? 8

What part of your time was spent supervising people? 6

Did you hire and fire employees? ☐ YES ☒ NO

J. Were you a lead worker? ☒ YES ☐ NO

SECTION 5 - MEDICATIONS

Do you currently take any **medications** for your illnesses, injuries or conditions? ☒ YES
If "YES," please tell us the following (Look at your medicine bottles, if necessary) ☐ NO

NAME OF MEDICINE	IF PRESCRIBED, GIVE NAME OF DOCTOR	REASON FOR MEDICINE	SIDE EFFECTS YOU HAVE
Paxil	Good Samaritan	DEPRESSION	DEPRESSION, Paranoia, memory loss
Zoloft	Cheryl Robinson	DEPRESSION	HALLUCINATIONS Paranoia
Ativan	Cheryl Robinson	DEPRESSION	MORE DEPRESSION
CLONIDINE	HOSPITAL STAY	DEPRESSION	ANXIETY
NORTRIPTYLINE	HOSPITAL STAY	DEPRESSION	CAN'T RECALL
EFFEXOR	DR. ADEGBILE	DEPRESSION	Blurred vision
EFFEXOR			NOISE

If you need more space, use Remarks, Section 9.

SECTION 6 - TESTS

Have you had, or will you have, any **medical tests** for illnesses, injuries or conditions?
☐ YES ☒ NO If "YES," please tell us the following (Give approximate dates, if necessary)

KIND OF TEST	WHEN DONE, OR WHEN WILL IT BE DONE? (Month, day, year)	WHERE DONE? (Name of Facility)	WHO SENT YOU FOR THIS TEST?
EKG (HEART TEST)			
TREADMILL (EXERCISE TEST)			
CARDIAC CATHETERIZATION			
BIOPSY--Name of body part			
HEARING TEST			
VISION TEST			
IQ TESTING			
EEG (BRAIN WAVE TEST)			
HIV TEST			
BLOOD TEST (NOT HIV)			
BREATHING TEST			
X-RAY--Name of body part			
MRI/CT SCAN Name of body part			

If you have had other tests, list them in Remarks, Section 9.

January 6, 2005, 14 48
PAGE 3

NT: [REDACTED] ALLICIA ESTER CALHOUN

agree that any payments from sources responsible for paying for medical are will go to the State if Medicaid already has paid for this care.

I do not have any private, group or government health insurance that pays the cost of my medical care

IMPORTANT INFORMATION--PLEASE READ CAREFULLY

We will check your statements and compare our records with records from other State and Federal agencies, including the Internal Revenue Service to make sure you are paid the correct amount

I understand that anyone who knowingly lies or misrepresents the truth or arranges for someone to knowingly lie or misrepresent the truth is committing a crime which can be punished under Federal law, State law, or both Everything on this application is the truth as best I know it

SIGNATURE

Allicia E. Calhoun
ALLICIA ESTER CALHOUN

DATE 1-11-04

Telephone Number: (727) 796-0699

Mailing Address. 702 BRIGADOON DR
CLEARWATER, FL 33759

January 6, 2005,
F

CLAIMANT [REDACTED] ALLICIA ESTER CALHOUN

I began living at 702 BRIGADOON DR, CLEARWATER, FL 33759 on
November 1, 2004

I live in a house/apartment/mobile home/houseboat.

I live with others

I do not expect these arrangements to change

REMARKS:

I CURRENTLY DO NOT HAVE ANY INCOME. I AM LIVING WITH MY SON AND HIS WIFE
THEY ARE SUPPORTING ME UNTIL I CAN BECOME SELF SUFFICIENT 01/06/05

o RESOURCES

I own the following from December 1, 2004 to continuing:

Checking account.

Financial institution name: PROVIDENT BANK IN OHIO

Value. \$20.00 From. December 2004 To: continuing

I do not own any other type of resource.

o INCOME

I receive or expect to receive the following income from December 1, 2004 to
continuing

Social Security

I do not receive any other type of income

o ELIGIBILITY FOR OTHER BENEFITS

I do not currently get food stamps.

o MEDICAID

You may be eligible for Medicaid. However, you must help your State identify
other sources that may pay for medical care. Also, you must give information
to help the State get medical support for any child(ren) who are your legal
responsibility. This includes information to help the State determine who a
child's father is

If you want Medicaid, you must agree to allow your State to seek payments
from sources, such as insurance companies, that are available to pay for you
~~medical care. This includes payments for medical care for you or any person~~
~~who receives Medicaid and is your legal responsibility. The State cannot~~
provide you Medicaid if you do not agree to this Medicaid requirement. If you
need further information, you may contact your Medicaid agency.

o MEDICAL ASSISTANCE

*** REC 2004345 114445 H71417E0 C999 CIPCMAC PCAC (F-C99) ***

Social Security Administration
Important Information

SOCIAL SECURITY
SUITE 500
600 CLEVELAND ST
CLEARWATER FL 33755
(727) 461-0481

ALLICIA ESTER CALHOUN
702 BRIGADOON DR
CLEARWATER FL 33759

Refer to: [REDACTED]
Telephone Appointment Confirmation

December 10, 2004
Phone: (800) 772-1213

Thank you for contacting us for a telephone appointment with our office. This is confirmation of the date and time of your telephone appointment. Please have this notice available when we call you for your appointment

Type Of Claim: Disability, Supplemental Security Income
Date Of Appointment: January 6, 2005
Time Of Appointment: 01:00 PM

Your Telephone Appointment

We will call you at the telephone number shown on our records, 727-796-0699. If this number is incorrect or changes, or if your address as shown above changes, please let us know where we can reach you. We will make every effort to call you at your scheduled appointment time. However, if our call is delayed, we will keep any delay to a minimum.

February 11, 2002

ALLICIA E CALHOUN
111 GRAFTON AVE APT 111
DAYTON, OH 45406

RE	Patient	ALLICIA E CALHOUN
	DOB	06/09/1958
	ID	[REDACTED]
	Employee Group	GM-NEW HIRES DAY (07627)

Dear Provider

United Behavioral Health (UBH) has the responsibility to manage the mental health/substance abuse benefits for this patient's benefit plan. The requested admission for this patient on 02/11/02 has been authorized. A total of 1 days have been initially authorized. The next scheduled review date is 02/12/02. A UBH case manager will communicate by telephone with the treatment staff in order to specify additional days authorized. You will receive notification of the total days authorized and the authorization number after discharge.

This authorization for coverage for MH/SA services is contingent upon the patient's eligibility and benefit plan limitations at the time of service and availability of remaining benefits. Any psychological testing requires specific authorization.

If you have any questions, please feel free to contact the UBH case manager at (614)527-5300, (800)358-0365 or FAX (888)329-0496.

Authorized by

Victor L Gaffin LCSW, LISW
Care Manager

cc
PROVIDER
FACILITY

Clmt# 410202128710



February 27, 2002

Alicia E Calhoun
5908 Verdi Drive
Dayton, Ohio 45449

Re Alicia E Calhoun
SS# [REDACTED]
Cisco 48085-086 Claim#410202128710

Dear Ms Calhoun

We have received your disability claim form on [date]

- ☐ We are however, unable to make a claims determination, as the information we received is incomplete
- ☐ Benefits will continue to be paid through Date at which time they will be suspended if this information is not received

Please provide the information checked below, and return it in the envelope provided, so that we may make a determination regarding your claim

- ☐ Have your attending physician complete his/her part of the form
- ☐ Answer question(s) [question number] on the employee part of the form
- ☐ Have your attending physician answer question(s) [question number] on his/her part of the form
- ☒ Other PLEASE COMPLETE THE ATTACHED REIMBURSEMENT AGREEMENT

Please be advised that if the above information is not received within 45 days from receipt of this letter, benefits may not be payable on your claim

Any questions you have regarding this matter should be referred to the National Benefit Center at 1-800-734-0346

Sincerely,

National Benefit Center
tlc

NATIONAL BENEFITS CENTER
Integrated Disability Activity
P O Box 5049
Southfield, Michigan 48086-5049
(800) 734-0346

February 28, 2002

Alicia E Calhoun
111 Grafton Ave #111
Dayton, OH 45406

RE Sickness and Accident Claim for Last Day Worked

Dear Ms Calhoun,

We have received your Statement of Claim for Sickness and Accident Benefits alleging that your disability was caused by your employment at General Motors

Following an investigation into your allegations we have concluded that your disability is not compensable under Ohio Workers' Compensation Law Therefore, your claim will be processed through the Metropolitan Group Insurance Plan

If you are alleging a new work-related injury or illness and you wish to dispute our findings, you have two (2) years from the date of injury/illness to file a First Report of Injury (FROI) with the Ohio Bureau of Worker's Compensation (BWC) This form is available at your local BWC office or upon request here at the National Benefit Center

Sincerely,



Tina Fodo
Integrated Disability Activity Representative

NATIONAL BENEFITS CENTER
Integrated Disability Activity
P O Box 5049
Southfield, Michigan 48086-5049
(800) 734-0346

February 28, 2002

Alicia E. Calhoun
111 Grafton Ave #111
Dayton, OH 45406

RE: Sickness and Accident Claim for Last Day Worked

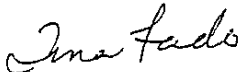
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Sincerely,



Tina Fodo
Integrated Disability Activity Representative

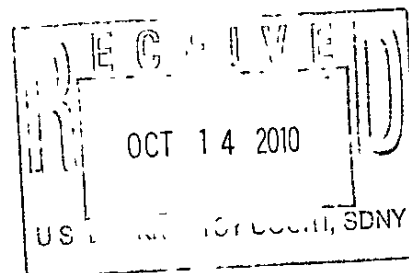
Largo , Florida
10/13/10

Clerk of the Bankruptcy Court
One Bowling Green
New York, New York 10004-1408



Claim # 28560	25,000 Yr 2002
Settlement offer	60,000 Yr 2003
	<u>75,000 Yr 2004</u>
	160,000 Income for 10 yrs service approximate
	100,000 Severance- Lose of company Bankruptcy

I was retired by GM in 2003 Seven months after I took a leave of absence, because of my ongoing battles with depression and misuse of prescription drugs
I filed for disability with social security in January of 2004 Also seeking compensation for lost benefits which I would be entitled to as a retired worker with a pension Original claim was for US\$346,000 00



03700581

APS0711866317



UNITED STATES BANKRUPTCY COURT FOR THE SOUTHERN DISTRICT OF NEW YORK

Name of Debtor (Check Only One)
☒ Motors Liquidation Company (f/k/a General Motors Corporation)
☐ MLCS, LLC (f/k/a Saturn, LLC)
☐ MLCS Distribution Corporation (f/k/a Saturn Distribution Corporation)
☐ MLC of Harlem, Inc. (f/k/a Chevrolet-Saturn of Harlem, Inc.)

Case No
 09-50026 (REG)
 09-50027 (REG)
 09-50028 (REG)
 09-13558 (REG)

NOTE: This form should not be used to make a claim for an administrative expense arising after the commencement of the case, but may be used for purposes of asserting a claim under 11 U.S.C. § 503(b)(9) (see Item # 5). All other requests for payment of an administrative expense should be filed pursuant to 11 U.S.C. § 503.

Name of Creditor (the person or other entity to whom the debtor owes money or property) ALLICIA E CALHOUN

Name and address where notices should be sent

ALLICIA E CALHOUN
 14330 58TH ST N APT 8103
 CLEARWATER, FL 33760-2826

☐ Check this box to indicate that this claim amends a previously filed claim

Court Claim Number _____
 (If known)

Filed on _____

Telephone number 727-474-5713
 e-mail address allicia.calhoun@yahoo.com

Name and address where payment should be sent (if different from above)

☐ Check this box if you are aware that anyone else has filed a proof of claim relating to your claim. Attach copy of statement giving particulars

☐ Check this box if you are the debtor or trustee in this case

Telephone number

Amount of Claim as of Date Case Filed, June 1, 2009 \$ 346,000.

If all or part of your claim is secured, complete item 4 below; however, if all of your claim is unsecured, do not complete item 4. If all or part of your claim is entitled to priority, complete item 5. If all or part of your claim is asserted pursuant to 11 U.S.C. § 503(b)(9), complete item 5.

☐ Check this box if claim includes interest or other charges in addition to the principal amount of claim. Attach itemized statement of interest or charges.

Basis for Claim LOSS OF INCOME/WAGES, TERMINATED
 (See instruction #2 on reverse side)

Last four digits of any number by which creditor identifies debtor. _____

3a Debtor may have scheduled account as _____
 (See instruction #3a on reverse side)

Secured Claim (See instruction #4 on reverse side)

Check the appropriate box if your claim is secured by a lien on property or a right of setoff and provide the requested information

Nature of property or right of setoff ☐ Real Estate ☐ Motor Vehicle ☐ Equipment ☐ Other Describe _____

Value of Property \$ _____ Annual Interest Rate % _____

Amount of arrearage and other charges as of time case filed included in secured claim, if any \$ _____

Basis for perfection _____

Amount of Secured Claim \$ _____ Amount Unsecured \$ _____

Credits The amount of all payments on this claim has been credited for the purpose of making this proof of claim

Documents Attach redacted copies of any documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements or running accounts, contracts, judgments, mortgages, and security agreements. You may also attach a summary. Attach redacted copies of documents providing evidence of perfection of security interest. You may also attach a summary. (See instruction 7 and definition of "redacted" on reverse side)

DO NOT SEND ORIGINAL DOCUMENTS ATTACHED DOCUMENTS MAY BE DESTROYED AFTER ANNOUNCING

If the documents are not available, please explain in an attachment

Signature The person filing this claim must sign it. Sign and print name and title, if any, of the creditor or other person authorized to file this claim and state address and telephone number if different from the notice address above. Attach copy of power of attorney, if any.
 Date 11/13/09
 Allicia E. Calhoun

PROOF OF CLAIM

Your Claim is Scheduled As Follows



If an amount is identified above, you have a claim scheduled by one of the Debtors as shown. (This scheduled amount of your claim may be an amendment to a previously scheduled amount.) If you agree with the amount and priority of your claim as scheduled by the Debtor and you have no other claim against the Debtor, you do not need to file this proof of claim form, EXCEPT AS FOLLOWS. If the amount shown is listed as DISPUTED, UNLIQUIDATED, or CONTINGENT, a proof of claim MUST be filed in order to receive any distribution in respect of your claim. If you have already filed a proof of claim in accordance with the attached instructions, you need not file again.

5 Amount of Claim Entitled to Priority under 11 U.S.C. § 507(a) If any portion of your claim falls in one of the following categories, check the box and state the amount

Specify the priority of the claim

- ☐ Domestic support obligations under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B)
- ☒ Wages, salaries, or commissions (up to \$10,950*) earned within 180 days before filing of the bankruptcy petition or cessation of the debtor's business, whichever is earlier - 11 U.S.C. § 507(a)(4)
- ☐ Contributions to an employee benefit plan - 11 U.S.C. § 507(a)(5)
- ☐ Up to \$2,425* of deposits toward purchase, lease, or rental of property or services for personal family or household use - 11 U.S.C. § 507(a)(7)
- ☐ Taxes or penalties owed to governmental units - 11 U.S.C. § 507(a)(8)
- ☐ Value of goods received by the Debtor within 20 days before the date of commencement of the case - 11 U.S.C. § 503(b)(9) (§ 507(a)(2))
- ☐ Other - Specify applicable paragraph of 11 U.S.C. § 507(a)()

Amount entitled to priority

\$ 346,000.00

*Amounts are subject to adjustment on 4/1/10 and every 3 years thereafter with respect to cases commenced on or after the date of adjustment - 11 U.S.C. § 507(a)(2)

FOR COURT USE ONLY

OCT 14 2010

U.S. BANKRUPTCY COURT, SDNY

INSTRUCTIONS FOR PROOF OF CLAIM FORM

The instructions and definitions below are general explanations of the law. In certain circumstances such as bankruptcy cases not filed voluntarily by the debtor, there may be exceptions to these general rules. The attorneys for the Debtors and their court-appointed claims agent, The Garden City Group, Inc., are not authorized and are not providing you with any legal advice.

A SEPARATE PROOF OF CLAIM FORM MUST BE FILED AGAINST EACH DEBTOR

PLEASE SEND YOUR ORIGINAL, COMPLETED CLAIM FORM AS FOLLOWS: IF BY MAIL, THE GARDEN CITY GROUP, INC., ATTN: MOTORS LIQUIDATION COMPANY CLAIMS PROCESSING, P.O. BOX 9385, DUBLIN, OH 43017-4286; IF BY HAND OR OVERNIGHT COURIER, THE GARDEN CITY GROUP, INC., ATTN: MOTORS LIQUIDATION COMPANY CLAIMS PROCESSING, 5151 BLAZER PARKWAY, SUITE A, DUBLIN, OH 43017. PROOFS OF CLAIM MAY ALSO BE HAND DELIVERED TO THE UNITED STATES BANKRUPTCY COURT, SDNY, ONE BOWLING GREEN, ROOM 534, NEW YORK, NEW YORK 10004. ANY PROOF OF CLAIM SUBMITTED BY FACSIMILE OR E-MAIL WILL NOT BE ACCEPTED.

THE GENERAL AND GOVERNMENTAL BAR DATE IS NOVEMBER 30, 2009 AT 5 00 P.M. (PREVAILING EASTERN TIME)

Court, Name of Debtor, and Case Number

These Chapter 11 cases were commenced in the United States Bankruptcy Court for the Southern District of New York on June 1, 2009. You should select the debtor against which you are asserting your claim.

A SEPARATE PROOF OF CLAIM FORM MUST BE FILED AGAINST EACH DEBTOR

Creditor's Name and Address

Fill in the name of the person or entity asserting a claim and the name and address of the person who should receive notices issued during the bankruptcy case. Please provide us with a valid email address. A separate space is provided for the payment address if it differs from the notice address. The creditor has a continuing obligation to keep the court informed of its current address. See Federal Rule of Bankruptcy Procedure (FRBP) 2002(g).

1. Amount of Claim as of Date Case Filed

State the total amount owed to the creditor on the date of the bankruptcy filing. Follow the instructions concerning whether to complete items 4 and 5. Check the box if interest or other charges are included in the claim.

2. Basis for Claim

State the type of debt or how it was incurred. Examples include goods sold, money loaned, services performed, personal injury/wrongful death, car loan, mortgage note, and credit card. If the claim is based on the delivery of health care goods or services, limit the disclosure of the goods or services so as to avoid embarrassment or the disclosure of confidential health care information. You may be required to provide additional disclosure if the debtor, trustee or another party in interest files an objection to your claim.

3. Last Four Digits of Any Number by Which Creditor Identifies Debtor

State only the last four digits of the debtor's account or other number used by the creditor to identify the debtor, if any.

3a. Debtor May Have Scheduled Account As

Use this space to report a change in the creditor's name, a transferred claim, or any other information that clarifies a difference between this proof of claim and the claim as scheduled by the debtor.

4. Secured Claim

Check the appropriate box and provide the requested information if the claim is fully or partially secured. Skip this section if the claim is entirely unsecured. (See DEFINITIONS, below.) State the type and the value of property that secures the claim, attach copies of lien documentation, and state annual interest rate and the amount past due on the claim as of the date of the bankruptcy filing.

5. Amount of Claim Entitled to Priority Under 11 U.S.C. § 507(a)

If any portion of your claim falls in one or more of the listed categories, check the appropriate box(es) and state the amount entitled to priority. (See DEFINITIONS, below.) A claim may be partly priority and partly non-priority. For example, in some of the categories, the law limits the amount entitled to priority.

For claims pursuant to 11 U.S.C. § 503(b)(9), indicate the amount of your claim arising from the value of any goods received by the debtor within 20 days before June 1, 2009, the date of commencement of these cases. (See DEFINITIONS, below.) Attach documentation supporting such claim.

6. Credits

An authorized signature on this proof of claim serves as an acknowledgment that when calculating the amount of the claim, the creditor gave the Debtor credit for any payments received toward the debt.

7. Documents

Attach to this proof of claim form redacted copies documenting the existence of the debt and of any lien securing the debt. You may also attach a summary. You must also attach copies of documents that evidence perfection of any security interest. You may also attach a summary FRBP 3001(c) and (d). If the claim is based on the delivery of health care goods or services, see instruction 2. Do not send original documents, as attachments may be destroyed after scanning.

Date and Signature

The person filing this proof of claim must sign and date it. FRBP 9011. If the claim is filed electronically, FRBP 5005(a)(2) authorizes courts to establish local rules specifying what constitutes a signature. Print the name and title, if any, of the creditor or other person authorized to file this claim. State the filer's address and telephone number if it differs from the address given on the top of the form for purposes of receiving notices. Attach a complete copy of any power of attorney. Criminal penalties apply for making a false statement on a proof of claim.

DEFINITIONS

INFORMATION

Debtor

A debtor is the person, corporation, or other entity that has filed a bankruptcy case. The Debtors in these Chapter 11 cases are:

Motors Liquidation Company (f/k/a General Motors Corporation)	09-50026 (REG)
MLCS, LLC (f/k/a Saturn, LLC)	09-50027 (REG)
MLCS Distribution Corporation (f/k/a Saturn Distribution Corporation)	09-50028 (REG)
MLC of Harlem, Inc. (f/k/a Chevrolet-Saturn of Harlem, Inc.)	09-13558 (REG)

Creditor

A creditor is the person, corporation, or other entity owed a debt by the debtor on the date of the bankruptcy filing.

Claim

A claim is the creditor's right to receive payment on a debt that was owed by the Debtor on the date of the bankruptcy filing. See 11 U.S.C. § 101(5). A claim may be secured or unsecured.

Proof of Claim

A proof of claim is a form used by the creditor to indicate the amount of the debt owed by the debtor on the date of the bankruptcy filing. The creditor must file the form with The Garden City Group, Inc. as described in the instructions above and in the Bar Date Notice.

Secured Claim Under 11 U.S.C. § 506(a)

A secured claim is one backed by a lien on property of the debtor. The claim is secured so long as the creditor has the right to be

paid from the property prior to other creditors. The amount of the secured claim cannot exceed the value of the property. Any amount owed to the creditor in excess of the value of the property is an unsecured claim. Examples of liens on property include a mortgage on real estate or a security interest in a car. A lien may be judicially granted by a debtor or may be obtained through a court proceeding. In some states, a court judgment is a lien. A claim also may be secured if the creditor owes the debtor money (has a right to setoff).

Section 503(b)(9) Claim

A Section 503(b)(9) claim is a claim for the value of any goods received by the debtor within 20 days before the date of commencement of a bankruptcy case in which the goods have been sold to the debtor in the ordinary course of such debtor's business.

Unsecured Claim

An unsecured claim is one that does not meet the requirements of a secured claim. A claim may be partly unsecured if the amount of the claim exceeds the value of the property on which the creditor has a lien.

Claim Entitled to Priority Under 11 U.S.C. § 507(a)

Priority claims are certain categories of unsecured claims that are paid from the available money or property in a bankruptcy case before other unsecured claims.

Redacted

A document has been redacted when the person filing it has masked, edited out, or otherwise deleted certain information. A creditor should redact and use only the last four digits of any social-security, individual's

tax-identification, or financial-account number, all but the initials of a minor's name and only the year of any person's date of birth.

Evidence of Perfection

Evidence of perfection may include a mortgage, lien, certificate of title, financing statement, or other document showing that the lien has been filed or recorded.

Acknowledgment of Filing of Claim

To receive acknowledgment of your filing from The Garden City Group, Inc., please provide a self-addressed, stamped envelope and a copy of this proof of claim when you submit the original claim to The Garden City Group, Inc.

Offers to Purchase a Claim

Certain entities are in the business of purchasing claims for an amount less than the face value of the claims. One or more of these entities may contact the creditor and offer to purchase the claim. Some of the written communications from these entities may easily be confused with official court documentation or communications from the debtor. These entities do not represent the bankruptcy court or the debtor. The creditor has no obligation to sell its claim. However, if the creditor decides to sell its claim, any transfer of such claim is subject to FRBP 3001(c), any applicable provisions of the Bankruptcy Code (11 U.S.C. § 101 et seq.), and any applicable orders of the bankruptcy court.

Additional Information

If you have any questions with respect to this claim form, please contact Alix Partners at 1 (800) 414-9607 or by e-mail at claims@motorsliquidation.com.

Social Security Administration Potential Private Pension Benefit Information

ALLICIA E CALHOUN
2718 WESTCHESTER DR N
CLEARWATER FL 33761

Social Security Number

Name A E CALHOUN

We are writing to tell you that you, or the worker whose Social Security number appears at the top of this form, MAY be entitled to some private pension benefits upon retirement. Also, your family, or the worker's family, may be entitled to retirement or survivor benefits

These Are Not Social Security Benefits

These potential benefits are NOT Social Security benefits and we do not make any decisions about the payment of these benefits. The following provides some basic information about these private pension benefits

Information About Pension Benefits

You have, or the worker has, earned pension rights although no longer employed in a job covered by the pension plan. These are called "deferred vested benefits." Private pension plan administrators must provide information about such benefits to us through the Internal Revenue Service. We provide this information about the pension plan when the individual asks for it or when a claim is filed for Social Security benefits

If You Want to Apply for These Benefits

If you want to apply for these pension benefits or have any questions, you should contact the pension Plan Administrator shown below. Include the 9 digit identification number shown below and a copy of this notice when you write to the Plan Administrator

Plan Name GENERAL MOTORS EMPLOYEE HOURLY-RATE EMPLOYEES PENSION PLAN	Plan Number 38-0572515-003	
	Identification Number 38-0572515	
	Year Reported 2003	Estimated Amount \$337
Plan Administrator and Address GENERAL MOTORS CORPORATION M/C 482-C16-D25 DETROIT MI 48265-3000	Type of Annuity C	Payment Frequency E
	Units or Shares	Value of Account

IMPORTANT: This is all the information we have. See the other side of this page for an explanation of this information

For SSA Use Only M03-115-65-005

2005075

Social Security Administration Potential Private Pension Benefit Information

ALLICIA E CALHOUN
2718 WESTCHESTER DR N
CLEARWATER FL 33761

Social Security Number

Name A E CALHOUN

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If You Want to Apply for These Benefits

If you want to apply for these pension benefits or have any questions, you should contact the pension Plan Administrator shown below. Include the 9 digit identification number shown below and a copy of this notice when you write to the Plan Administrator.

Plan Name GENERAL MOTORS PERSONAL SAVINGS PLAN FOR HOURLY-RATE EMPLOYEES IN	Plan Number 38-0572515-014	
	Identification Number 38-0572515	
	Year Reported 2003	Estimated Amount
Plan Administrator and Address GENERAL MOTORS CORPORATION AND SUBSIDIARIES PO BOX 300 DETROIT MI 48265-3000	Type of Annuity A	Payment Frequency A
	Units or Shares	Value of Account \$3,447

IMPORTANT: This is all the information we have. See the other side of this page for an explanation of this information.

For SSA Use Only M04-014-31-023

2005075

EXPLANATION OF INFORMATION

YEAR REPORTED

This is the year for which the Plan Administrator reported the pension plan information to the Internal Revenue Service

ESTIMATED ACCOUNT

This was the amount that would be paid under the plan then in effect. The actual amount could differ because of later changes in the plan. If you have already received payments from the plan, the amount shown on this notice should be disregarded.

TYPE OF ANNUITY

The code listed identifies the type of annuity to be paid:

- A** A single payment of a lump sum
- B** Annuity payable over a fixed number of years
- C** Life annuity
- D** Life annuity with period certain
- E** Cash refund life annuity
- F** Modified cash refund life annuity
- G** Joint and last survivor annuity
- M** Other (Type of annuity not reported)

PAYMENT FREQUENCY

The code listed shows how often the estimated payments would be made under the plan:

- | | |
|------------------------|---|
| A Lump Sum | E Monthly |
| B Annually | M Other (Payment frequency not reported) |
| C Semi-Annually | |
| D Quarterly | |

UNITS OR SHARES

If the pension amount is based on units or shares, the number of units or shares will be shown. The number of shares will be shown followed by "S".

VALUE OF ACCOUNT

If shown, this indicates the value of the account at the time the worker stopped working under the plan.

WRONG ADDRESS OR COMPLAINTS

If you cannot locate the Plan Administrator at the address shown on this notice, contact your former employer for the current address. If you cannot locate your former employer, check the reference department of your local library or contact your State's corporation commission. This agency should be in the telephone book under State government.

If you have a complaint about the way the private pension plan has handled your claim, contact the local office of the Department of Labor's Pension and Welfare Benefits Administration. If this office is not listed in your telephone directory, write to the Department of Labor, Pension and Welfare Benefits Administration, Room N-5619, 200 Constitution Avenue N.W., Washington, DC 20210.

If you have any other Questions, call us toll free at 1-800-772-1213.

DISABILITY REPORT - ADULT - Form SSA-3368-BK

PLEASE READ ALL OF THIS INFORMATION BEFORE YOU BEGIN
COMPLETING THIS FORM

IF YOU NEED HELP

If you need help with this form, do as much of it as you can, and your interviewer will help you finish it. However, if you have access to the Internet, you may access the Disability Report Form Guide at <http://www.ssa.gov/disability/3368/>

HOW TO COMPLETE THIS FORM

The information that you give us on this form will be used by the office that makes the disability decision on your disability claim. You can help them by completing as much of the form as you can

- Please fill out as much of this form as you can before your interview appointment
- Print or type.
- **DO NOT LEAVE ANSWERS BLANK** If you do not know the answers, or the answer is "none" or "does not apply," please write "don't know," or "none," or "does not apply."
- **IN SECTION 4, PUT INFORMATION ON ONLY ONE DOCTOR/HOSPITAL/CLINIC IN EACH SPACE.**
- Each address should include a ZIP code. Each telephone number should include an area code.
- **DO NOT ASK A DOCTOR OR HOSPITAL TO COMPLETE THE FORM.** However, you can get help from other people, like a friend or family member.
- If your appointment is for an interview by telephone, have the form ready to discuss with us when we call you
- If your appointment is for an interview in our office, bring the completed form with you or mail it ahead of time, if you were told to do so.
- When a question refers to "you," "your" or the "Disabled Person," it refers to the person who is applying for disability benefits. If you are filling out the form for someone else, please provide information about him or her.
- Be sure to explain an answer if the question asks for an explanation, or if you want to give additional information
- If you need more space to answer any questions or want to tell us more about an answer, please use the "REMARKS" section on Pages 9 and 10, and show the number of the question being answered.

ABOUT YOUR MEDICAL RECORDS

If you have any medical records and copies of prescriptions at home for the person who is applying for disability benefits, send them to our office with your completed forms or bring them with you to your interview. Also, bring any prescription bottles with you. If you need the records back, tell us and we will photocopy them and return them to you.

YOU DO NOT NEED TO ASK DOCTORS OR HOSPITALS FOR ANY MEDICAL RECORDS THAT YOU DO NOT ALREADY HAVE. With your permission, we will do that for you. The information we ask for on this form tells us to whom we should send a request for medical and other records. If you cannot remember the names and addresses of any of the doctors or hospitals, or the dates of treatment, perhaps you can get this information from the telephone book, or from medical bills, prescriptions and prescription bottles.

SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No 0960-0579

**DISABILITY REPORT
ADULT**

For SSA Use Only

Do not write in this box

Related SSN _____

Number Holder _____

SECTION 1- INFORMATION ABOUT THE DISABLED PERSON

A. NAME (First, Middle Initial, Last)

ALLICIA E CALHOUN

B SOCIAL SECURITY NUMBER

[REDACTED]

C. DAYTIME TELEPHONE NUMBER (If you have no number where you can be reached, give us a daytime number where we can leave a message for you)

Area
Code

Number

☐

Your Number

☐

Message Number

☐

None

D Give the name of a friend or relative that we can contact (other than your doctors) who knows about your illnesses, injuries or conditions and can help you with your claim.

NAME CARSON DOUGLAS

RELATIONSHIP FRIEND

ADDRESS 1022 DANNER AVE. #B

(Number, Street, Apt No (If any), P O Box, or Rural Route)

DAYTON, OHIO 45408

City

State

ZIP

DAYTIME
PHONE

937
Area Code

586-0831
Number

E. What is your height without shoes?

5
feet

5 3/4
inches

F What is your weight without shoes?

169
pounds

G Do you have a medical assistance card? (For Example, Medicaid or Medi-Cal) If "YES," show the number here. ☐ YES ☒ NO

H. Can you speak English? ☒ YES ☐ NO If "NO," what languages can you speak? _____

If you **cannot speak English**, is there someone we may contact who speaks English and will give you messages? (If this is the same person as in "D" above show "SAME" here)

NAME _____

RELATIONSHIP _____

ADDRESS _____

(Number, Street, Apt No (If any), P O Box, or Rural Route)

City State ZIP

DAYTIME
PHONE

Area Code

Number

I. Can you read English? ☒ YES ☐ NO **J. Can you write more than your name in English?** ☒ YES ☐ NO

Disability Report-Adult-Form SSA-3368-BK

SECTION 2
YOUR ILLNESSES, INJURIES OR CONDITIONS AND HOW THEY AFFECT YOU

A. What are the illnesses, injuries or conditions that limit your ability to work? *Major Depress*
ANXIETY, hyperventilate, panic attacks.

foot injury, deformation of character, discrimination. Diminished
sense of self worth. Constant harassment, No support from family or un.

B. How do your illnesses, injuries or conditions limit your ability to work? *Became para*
The drugs they prescribed worsened my condition to where I would s
in the house for days at a time. I would call in to work and go see my
she wasn't any help. I couldn't get any relief or help no matter w
or where. I turned. The people I did turn to seemed to be my ene
too. At least in my mind. They were trying to poison me.

C. Do your illnesses, injuries or conditions cause you pain ☒ YES ☐ NO
or other symptoms?

D. When did your illnesses, injuries or conditions first bother you?

Month <i>9</i>	Day <i>9</i>	Year <i>97</i>
-------------------	-----------------	-------------------

E. When did you become unable to work because of your illnesses, injuries or conditions?

Month	Day	Year
-------	-----	------

F. Have you ever worked?

☒ YES ☐ NO (If "NO," go to Section 4)

G. Did you work at any time after the date your illnesses, injuries or conditions first bothered you?

☒ YES ☐ NO

H. If "YES," did your illnesses, injuries or conditions cause you to (check all that apply)

- ☒ work fewer hours? (Explain below)
☒ change your job duties? (Explain below)
☒ make any job-related changes such as your attendance, help needed, or employers?
(Explain below)

I was put on restrictions from my Dr. which GM did honor. Then they tried to fire me but I was on scratches for work stoppage. This is when my decline began when I first became mentally challenged. After I hurt m
at work. I felt as if I had been star

I. Are you working now?

☒ YES ☐ NO

If "NO," when did you stop working?

Month	Day	Year
-------	-----	------

J. Why did you stop working?

SECTION 3 - INFORMATION ABOUT YOUR WORK

A. List the kinds of jobs that you have had in the last 15 years that you worked

JOB TITLE (Example, Cook)	TYPE OF BUSINESS (Example, Restaurant)	DATES WORKED (month & year)		HOURS PER DAY	DAYS PER WEEK	RATE OF PAY (Per hour, day, week, month or year)	
		From	To				
GIM	Group leader	Oct	Apr 02	10	4	\$	21.00
BAT Co Bd of Ed	Cafeteria Worker	Apr	Sept	4.5	5	\$	9.00
Kmart	Supervisor	Apr	Sept	8	4	\$	6.75
NCR	Group leader	Oct	Jan 9	8	5	\$	13.00
Weight Patt AFB	Week	Jun	Aug	5	5	\$	5.00
						\$	
						\$	

B. Which job did you do the longest? NCR

C. Describe this job. What did you do all day? (If you need more space, write in the "Remarks" section.)

DRIVE forklift, shipping + receiving, pay roll
tore down parts (computer) Supervised 8 people. answered phone

D. In this job, did you:

Use machines, tools or equipment?

☒ YES ☐ NO

Use technical knowledge or skills?

☒ YES ☐ NO

Do any writing, complete reports, or perform duties like this?

☒ YES ☐ NO

E. In this job, how many total hours each day did you:

Walk? 6 Stoop? (Bend down & forward at waist) 0

Handle, grab or grasp big objects? 5

Stand? 2 Kneel? (Bend legs to rest on knees) 0

Reach? 2

Sit? 3 Crouch? (Bend legs & back down & forward) 0

Write, type or handle small objects? 2

Climb? 1 Crawl? (Move on hands & knees) 0

F. Lifting and Carrying (Explain what you lifted, how far you carried it, and how often you did this.)

Off a truck to a skid.

G. Check heaviest weight lifted

☐ Less than 10 lbs ☐ 10 lbs ☒ 20 lbs ☐ 50 lbs ☐ 100 lbs or more ☐ Other

H. Check weight frequently lifted (By frequently, we mean from 1/3 to 2/3 of the workday)

☒ Less than 10 lbs ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs or more ☐ Other

I. Did you supervise other people in this job? ☒ YES (Complete items below) ☐ NO (Skip to next page)

How many people did you supervise? 8

What part of your time was spent supervising people? 6

Did you hire and fire employees? ☐ YES ☒ NO

J. Were you a lead worker? ☒ YES ☐ NO

SECTION 5 - MEDICATIONS

Do you currently take any **medications** for your illnesses, injuries or conditions? ☒ YES
If "YES," please tell us the following. (Look at your medicine bottles, if necessary) ☐ NO

NAME OF MEDICINE	IF PRESCRIBED, GIVE NAME OF DOCTOR	REASON FOR MEDICINE	SIDE EFFECTS YOU HAVE
Paxil	GOOD Samaritan	DEPRESSION	DEPRESSION, Paranoia, memory loss
Zoloft	Cheryl Robinson	DEPRESSION	HALLUCINATIONS Paranoia
Ativan	Cheryl Robinson	DEPRESSION	MORE DEPRESSION
CLONIDINE	HOSPITAL STAY	DEPRESSION	ANXIETY
NORTRIPTYLINE	HOSPITAL STAY	DEPRESSION	CAN'T RECALL
EFFEXOR	DR. ADEGBILE	DEPRESSION	Blurred vision Nausea

~~EFFEXOR~~

If you need more space, use Remarks, Section 9.

SECTION 6 - TESTS

Have you had, or will you have, any **medical tests** for illnesses, injuries or conditions?
☐ YES ☒ NO If "YES," please tell us the following (Give approximate dates, if necessary)

KIND OF TEST	WHEN DONE, OR WHEN WILL IT BE DONE? (Month, day, year)	WHERE DONE? (Name of Facility)	WHO SENT YOU FOR THIS TEST?
EKG (HEART TEST)			
TREADMILL (EXERCISE TEST)			
CARDIAC CATHETERIZATION			
BIOPSY--Name of body part			
HEARING TEST			
VISION TEST			
IQ TESTING			
EEG (BRAIN WAVE TEST)			
HIV TEST			
BLOOD TEST (NOT HIV)			
BREATHING TEST			
X-RAY--Name of body part			
MRI/CT SCAN Name of body part			

If you have had other tests, list them in Remarks, Section 9.

NT.

ALLICIA ESTER CALHOUN

agree that any payments from sources responsible for paying for medical care will go to the State if Medicaid already has paid for this care.

I do not have any private, group or government health insurance that pays the cost of my medical care.

IMPORTANT INFORMATION--PLEASE READ CAREFULLY

We will check your statements and compare our records with records from other State and Federal agencies, including the Internal Revenue Service to make sure you are paid the correct amount.

I understand that anyone who knowingly lies or misrepresents the truth or arranges for someone to knowingly lie or misrepresent the truth is committing a crime which can be punished under Federal law, State law, or both. Everything on this application is the truth as best I know it.

SIGNATURE

Allicia E. Calhoun
ALLICIA ESTER CALHOUN

DATE

1-11-04

Telephone Number: (727) 796-0699

Mailing Address: 702 BRIGADOON DR
CLEARWATER, FL 33759

January 6, 2005,
F

CLAIMANT: [REDACTED] ALLICIA ESTER CALHOUN

I began living at 702 BRIGADOON DR, CLEARWATER, FL 33759 on
November 1, 2004

I live in a house/apartment/mobile home/houseboat.

I live with others

I do not expect these arrangements to change

REMARKS.

I CURRENTLY DO NOT HAVE ANY INCOME. I AM LIVING WITH MY SON AND HIS WIFE.
THEY ARE SUPPORTING ME UNTIL I CAN BECOME SELF SUFFICIENT. 01/06/05

o RESOURCES

I own the following from December 1, 2004 to continuing:

Checking account

Financial institution name: PROVIDENT BANK IN OHIO

Value: \$20.00 From December 2004 To continuing

I do not own any other type of resource.

o INCOME

I receive or expect to receive the following income from December 1, 2004 to
continuing.

Social Security

I do not receive any other type of income.

o ELIGIBILITY FOR OTHER BENEFITS

I do not currently get food stamps

o MEDICAID

You may be eligible for Medicaid. However, you must help your State identify
other sources that may pay for medical care. Also, you must give information
to help the State get medical support for any child(ren) who are your legal
responsibility. This includes information to help the State determine who a
child's father is

If you want Medicaid, you must agree to allow your State to seek payments
from sources, such as insurance companies, that are available to pay for your
medical care. This includes payments for medical care for you or any person
who receives Medicaid and is your legal responsibility. The State cannot
provide you Medicaid if you do not agree to this Medicaid requirement. If you
need further information, you may contact your Medicaid agency.

o MEDICAL ASSISTANCE

*** REC 2004345 114445 H71417E0 C999 CIPCMAC PCAC (F-C99) ***

Social Security Administration
Important Information

SOCIAL SECURITY
SUITE 500
600 CLEVELAND ST
CLEARWATER FL 33755
(727) 461-0481

ALLICIA ESTER CALHOUN
702 BRIGADOON DR
CLEARWATER FL 33759

Refer to: [REDACTED]
Telephone Appointment Confirmation

December 10, 2004
Phone: (800) 772-1213

Thank you for contacting us for a telephone appointment with our office. This is confirmation of the date and time of your telephone appointment. Please have this notice available when we call you for your appointment.

Type Of Claim: Disability, Supplemental Security Income
Date Of Appointment: January 6, 2005
Time Of Appointment: 01:00 PM

Your Telephone Appointment

We will call you at the telephone number shown on our records, 727-796-0699. If this number is incorrect or changes, or if your address as shown above changes, please let us know where we can reach you. We will make every effort to call you at your scheduled appointment time. However, if our call is delayed, we will keep any delay to a minimum.

February 11, 2002

ALLICIA E CALHOUN
111 GRAFTON AVE APT 111
DAYTON OH 45406

RE Patient ALLICIA E CALHOUN
DOB 06/09/1958
ID [REDACTED]
Employer Group GM-NEW HIRES DAY (07627)

Dear Provider

United Behavioral Health (UBH) has the responsibility to manage the mental health/substance abuse benefits for this patient's benefit plan. The requested admission for this patient on 02/11/02 has been authorized. A total of 1 day has been initially authorized. The next scheduled review date is 02/12/02. A UBH case manager will communicate by telephone with the treatment staff in order to specify additional days authorized. You will receive notification of the total days authorized and the authorization number after discharge.

This authorization for coverage for MH/SA services is contingent upon the patient's eligibility and benefit plan limitations at the time of service and availability of remaining benefits. Any psychological testing requires specific authorization.

If you have any questions, please feel free to contact the UBH case manager at (614)527-5300, (800)358-0365 or FAX (888)329-0496.

Authorized by

Victor L Gaffin LCSW, LISW
Care Manager

cc
PROVIDER
FACILITY



February 27, 2002

Alicia E. Calhoun
5908 Verdi Drive
Dayton, Ohio 45449

Re: Alicia E. Calhoun
SS# [REDACTED]
Cisco 48085-086 Claim#410202128710

Dear Ms. Calhoun:

We have received your disability claim form on [date]

- ☐ We are however, unable to make a claims determination, as the information we received is incomplete
- ☐ Benefits will continue to be paid through Date at which time they will be suspended if this information is not received

Please provide the information checked below, and return it in the envelope provided, so that we may make a determination regarding your claim

- ☐ Have your attending physician complete his/her part of the form
- ☐ Answer question(s) [question number] on the employee part of the form
- ☐ Have your attending physician answer question(s) [question number] on his/her part of the form
- ☒ Other PLEASE COMPLETE THE ATTACHED REIMBURSEMENT AGREEMENT

Please be advised that if the above information is not received within 45 days from receipt of this letter, benefits may not be payable on your claim.

Any questions you have regarding this matter should be referred to the National Benefit Center at 1-800-734-0346

Sincerely,

National Benefit Center
tlc

✓

NATIONAL BENEFITS CENTER
Integrated Disability Activity
P O Box 5049
Southfield, Michigan 48086-5049
(800) 734-0346

February 28, 2002

Alicia E Calhoun
111 Grafton Ave #111
Dayton, OH 45406

RE Sickness and Accident Claim for Last Day Worked

Dear Ms Calhoun,

We have received your Statement of Claim for Sickness and Accident Benefits alleging that your disability was caused by your employment at General Motors

Following an investigation into your allegations we have concluded that your disability is not compensable under Ohio Workers' Compensation Law Therefore, your claim will be processed through the Metropolitan Group Insurance Plan

If you are alleging a new work-related injury or illness and you wish to dispute our findings, you have two (2) years from the date of injury/illness to file a First Report of Injury (FROI) with the Ohio Bureau of Worker's Compensation (BWC) This form is available at your local BWC office or upon request here at the National Benefit Center

Sincerely,



Tina Fodo
Integrated Disability Activity Representative

NATIONAL BENEFITS CENTER
Integrated Disability Activity
P O Box 5049
Southfield, Michigan 48086-5049
(800) 734-0346

February 28, 2002

Alicia E Calhoun
111 Grafton Ave #111
Dayton, OH 45406

RE Sickness and Accident Claim for Last Day Worked

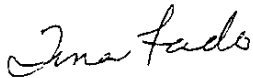
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Following an investigation into your allegations we have concluded that your disability is not compensable under Ohio Workers' Compensation Law Therefore, your claim will be processed through the Metropolitan Group Insurance Plan

If you are alleging a new work-related injury or illness and you wish to dispute our findings, you have two (2) years from the date of injury/illness to file a First Report of Injury (FROI) with the Ohio Bureau of Worker's Compensation (BWC) This form is available at your local BWC office or upon request here at the National Benefit Center

Sincerely,



Tina Fodo
Integrated Disability Activity Representative

09-50026-ma Doc 12058
ORIGIN ID PIER (727) 584-2992
ALLICIA CALHOUN
PAK MAIL
10500 ULMERTON RD
SUITE 726
LARGO, FL 33771
UNITED STATES US

Filed 09/14/12 Entered 09/14/12 16:01:39
SHIP DATE 13 OCT 12
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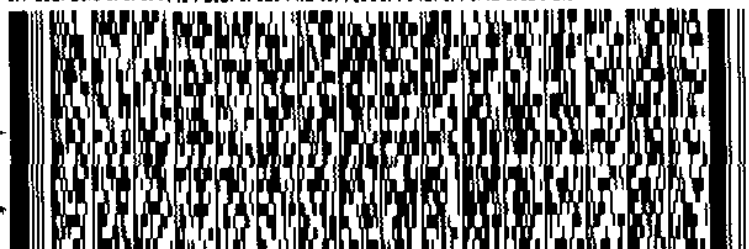
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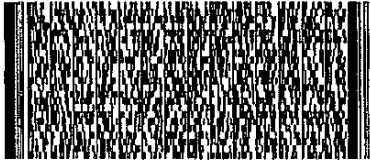
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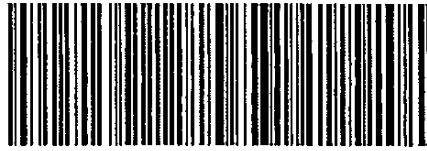
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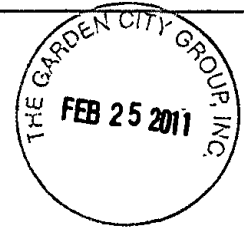
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Kimberly Gargan

Subject: FW MLC - PoC 28560 Alicia E Calhoun

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From: Tseng, Conray [<mailto:conray.tseng@weil.com>]
Sent: Tuesday, February 22, 2011 5:10 PM
To: 'alliciacalhoun@yahoo.com'
Cc: Griffiths, David; 'Barr, Ben'; Huffman, Brian
Subject: MLC - PoC 28560 Alicia E. Calhoun



Dear Ms. Calhoun

This e-mail confirms our phone conversation. The priority amount of your claim will be adjusted from \$346,000 to \$10,950 in accordance with the statutory cap. You will still have a general unsecured claim in the amount of \$346,000.

We reserve all rights with respect to your claim. Please reply back confirming your agreement with the above.

Thank you for your assistance with this matter.

Weil

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